



IOM International Organization for Migration
OIM Organisation Internationale pur les Migrations
OIM Organización Internacional para las Migraciones

FACILITATION OF THE RECRUITMENT AND PLACEMENT OF FOREIGN HEALTH CARE PROFESSIONALS TO WORK IN THE PUBLIC SECTOR HEALTH CARE IN SOUTH AFRICA



ASSESSMENT CONDUCTED IN THE NETHERLANDS, THE UNITED KINGDOM, AND THE UNITED STATES

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The International Organization for Migration (IOM) Regional Office for Southern Africa is pleased to launch the report “Facilitation of the Recruitment and Placement of Foreign Health Care Professionals to Work in the Public Sector Health Care in South Africa”, which is based on an assessment conducted in the Netherlands, the United Kingdom, and the United States.

The report provides an overview of the dynamics of health worker migration from and to South Africa and the health care human resources environment in the three countries. It also identifies and maps relevant institutions and associations in the three selected countries to assess the interest and availability of foreign health care professionals to work in the public sector in South Africa. Lastly, the assessment recommends future activities that aim to strengthen the capacity of the public sector health care services in South Africa by facilitating the recruitment and placement of foreign health care professionals as well as South African health workers currently residing in the Diaspora in the three selected countries.

The process of this assessment involved substantial inputs and cooperation from over 80 experts, practitioners, and other stakeholders, whose names are listed in Appendix B. We are confident, therefore, that this broad participation has contributed to making this assessment comprehensive. It is our hope that policy makers and stakeholders will actively use the findings and recommendations of this assessment to guide future activities and programming to alleviate the challenges in the area of human resource for health in South Africa.

We would like to acknowledge and thank our partner, the Department of Health of the Republic of South Africa, particularly the Policy Research and Planning Cluster of the Human Resources Branch, for their support and consultation.



Hans-Petter Boe

IOM Regional Representative for Southern Africa

Managed migration strategies could increase South Africa's human resource capacity to deliver quality services to rural and other underserved areas. This assessment reviews health care labour migration flows and the human resource environment between the Netherlands, the UK, the US, and South Africa. The assessment maps relevant institutions and associations, which could be targeted for recruitment to address some of the country's critical health care human resource needs, and identifies a network of relevant stakeholders. Finally, the assessment provides migration-relevant recommendations for policies and programmes.

Studies indicate that health care worker migration is precipitated by “push and pull” factors, moderated by “stick and stay” factors between source and destination countries. Whilst migration flows reflect individual decisions to maximise welfare, structural factors (e.g. trade liberalisation and migration regimes) explain directionality, shifts, and overall magnitudes. Better salaries, benefits, and job satisfaction, organisational environments, equipment, research and career opportunities, education/training, and protection from occupational risks attract health workers to destination countries. Fear of crime, discrimination, instability, and poor working conditions cause many health workers to leave.

Western Europe and North America with aging populations have an increasing demand for health workers and recruit abroad. They also limit young entrants into the workforce whilst requiring large numbers of junior employees. International codes of practice and bilateral memoranda of understanding have decreased international recruitment for the public sector; however, the demand in the private sector continues. Putting in place measures to restrict migration has also caused some health care workers to leave their professions altogether.

Globally, South Africa is ranked as having moderate losses of health care workers. South African doctors emigrate at a rate of about 1000 annually. In 2003, there were an estimated 4000 vacancies for doctors in the public sector. Since South Africa subsidises medical education, the financial loss when doctors and nurses leave is estimated at \$US one billion a year. Addressing the country's losses would also benefit other countries in the SADC region, whose workers are attracted to South Africa by its higher salaries and better opportunities. Although South Africa has a policy of not issuing work visas to health professionals from developing countries, some manage to find work and work permits through other, sometimes irregular, means.

Amongst OECD countries, only Australia and the UK number South African doctors in their top three origin countries. South Africans comprise 9.7% of foreign-trained doctors in Australia and 7% of those in the UK. The top four destination countries – the US, Canada, New Zealand, and Australia – have 6993 South African doctors registered in their workforces, comprising 18.53% of the 30,740 registered physicians in South Africa.

Despite fears of an international “brain drain”, the majority of South African health care personnel losses are from the public to the private sector and from rural to urban areas. Labour migration is increasingly privatised and, therefore, difficult to track. Skilled health care personnel are also lost to development projects, which pay higher than the local market rates. In addition, significant health care worker losses are due to HIV and AIDS morbidity and mortality. HIV and AIDS pose increased occupational risks and lead to fatigue and desperation with dealing with this and other communicable diseases that are growing in prevalence.

Addressing South Africa's health care shortages will not be resolved by restricting migration opportunities and, indeed, migration flows are likely to be part of the solution. Attracting people to the areas of greatest need requires creating the right set of incentives and support. Encouraging different forms of migration and exchanges may help in providing the resources, energy and commitment to address critical HIV and AIDS and other disease morbidity and mortality.

Private and public health worker exchanges, ranging from brief visits to permanent returns, are already underway between South Africa and the three countries that were assessed. Foreign and Diaspora health care workers are also willing to consider migrating for short periods and/or returning permanently. Health care workers in all three countries are attracted to work in South Africa in order to enhance their scope of practice and to gain new knowledge and experience. Nevertheless, Diaspora health workers may fear crime, falling living standards, affirmative action, and not being welcomed back. Doctors with defined career tracks, particularly in the US, are also less likely to return than other health care workers. Such impediments suggest the value of staged, well-organised returns to support health care workers generally and to allow the Diaspora to test out their concerns and assumptions directly.

In the Netherlands, recent medical graduates of between 25 and 30 years of age would be willing to volunteer for two to three years. Those at the end of their career (55 years and older) would consider volunteering for longer periods. Future promising exchanges are with KIT's Royal Tropical Institute of Medicine, which provides infectious disease specialists and training for specialists from other countries. Worldwide Surgery is also developing an online registration service to match interested physicians with overseas openings. Through the Stellenbosch Foundation, Diaspora doctors are investing in medical school equipment and rural scholarships. They also return periodically to provide training, which suggests a model for other Diaspora engagement.

The UK Government has committed GBP one million over the next two years to assist the Global Health Workforce Alliance to address the lack of health care workers in poor countries. The Memorandum of Understanding between the UK and South Africa also provides for a limited number of exchanges. The Rural Health Initiative has placed over 125 UK doctors for one- to three-year assignments in rural clinics and hospitals with shortages and plans to expand its work. The King's Fund provides former UK National Health Service administrators to assist in HR management and administration. Amongst the South African Diaspora, a group of nurses would like to return and Netcare, in collaboration with the Homecoming Revolution, has already returned over 60 nurses to private institutions.

In 2006, the US Government's President's Emergency Plan for AIDS Relief (PEPFAR) invested some \$US 350 million (25% of its funding) on health workforce and systems development in priority countries, including South Africa. This assistance, accessed through national plans, supports: policy reforms towards task-shifting; development of information systems; human resource assessments; training support for community health workers; retention strategies; and twinning partnerships. To date, South African assistance has trained Persons Living with HIV (PLWHs) to serve as community health workers. The Placement Project is also instituting PEPFAR internships and placements to rural areas. Within the US, several medical schools support the Institute of Medicine's proposal for a Global Health Service. Yale Medical School and Massachusetts MED have already organised South African exchanges. Coordination of these exchanges could be enhanced with registration on a centralised database. Such exchanges are likely to be most effective through partnerships with South African medical schools and hospitals to create "centres of excellence".

The mobility of labour is both a domestic and international phenomenon. Thus, migration strategies may include: (1) retaining health care workers in their region and/or promoting new internal flows of these workers to address critical health care shortages; (2) attracting Diaspora health care workers back to South Africa; and (3) encouraging short-term migration of foreign health care workers. Retaining health care workers requires a proper mix of incentives and effective management of all available resources, rather than restricting mobility or labour flows to the private sector. Promoting official international collaborative partnerships and exchanges encourages Diaspora and other foreign health workers to work in South Africa. Since the current shortages affect both the public and private sectors, the resolution requires public-private cooperation. Thus, financing and organisation of international exchanges – twinning relationships and partnerships to support rural centres of excellence – should be sought through both private and public funding sources in order to sustain the work ahead.

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LIST OF ABBREVIATIONS

ACHAP	African Comprehensive HIV and AIDS Partnerships
AIDS	Acquired Immune Deficiency Syndrome
CDC	Center for Disease Control
CIDA	Canadian International Development Agency
DfID	UK Department for International Development
DOH	Department of Health
EU	European Union
EEA	European Economic Area
EFTA	European Free Trade Area
ESA	Eastern and Southern Africa
EQUINET	Regional Network for Equity in Health in Southern Africa
FOMSS	Friends of Mosvold Scholarship Scheme
GMC	General Medical Council
GWU	George Washington University
HIV	Human Immuno-deficiency Virus
HR	Human Resource
IDDI	Inter-Diaspora Dialogue Initiative
IFPMA	International Federation of Pharmaceutical Manufacturers and Associations
IMGs	International Medical Graduates
IOM	International Organization for Migration
MCH	Maternal and Child Health
MESAB	Medical Education for South African Blacks
MFA	Ministry of Foreign Affairs
MIDA	Migration for Development in Africa
MOU	Memorandum of Understanding
MPH	Masters in Public Health
NGO	Non-governmental Organisation
NHS	National Health Service
NIH	National Institutes of Health
NMC	Nursing and Midwifery Council
PATH	Program for Appropriate Technology in Health

PEPFAR	President’s Emergency Plan for AIDS Relief
PHRplus	Partners for Health Reform plus
PIP	PEPFAR Internship Program
PLAB	Professional Linguistic Assessment Boards
PLWHs	Persons Living with HIV
QA	Quality Assurance
RHI	Rural Health Initiatives
RUDASA	Rural Doctors Association of South Africa
RQAN	Return of Qualified African Nationals
SAS	Statistical Analysis System
SA Partners	South African Partners
THET	Tropical Health and Education Trust
TFG	Training Resources Group
UCLA	University of California/Los Angeles
UK	United Kingdom
UN	United Nations
UNC	University of North Carolina
US	United States
USAID	US Agency for International Development
WD	Workforce Development
WIRHE	Wits Initiative for Rural Health Education
WHO	World Health Organization

1. INTRODUCTION

This report is the culmination of a review undertaken between November 2006 and April 2007 to assess the feasibility of and interest among various relevant stakeholders in the Netherlands, the UK, and the US in facilitating recruitment and placement of foreign health care professionals, including those among the Diaspora, to work in the public sector health care in South Africa. The review involved: 1) a desk study to provide an overview of the dynamics of health worker migration from and to South Africa; 2) a desk study to provide an overview of the health care human resources (HR) environment in the Netherlands, the UK, and the US; 3) field visits and a survey to identify and map relevant institutions and associations in the Netherlands, the UK, and the US; and 4) the development of recommendations for future partnerships and activities.

It is envisaged that the findings and recommendations of this study will inform future policies and programming in strengthening the capacity of the public sector health care services in South Africa. South Africa's national Department of Health (DOH) requested the International Organization for Migration's (IOM) Regional Mission in Pretoria to conduct this assessment, which was then carried out in collaboration with other IOM missions in London, The Hague, and Washington, D.C.

Founded in 1951, IOM is an intergovernmental agency with 120 member states (as of July 2007) and headquarters in Geneva. IOM is committed to the principle that humane and orderly migration benefits migrants and society. The organisational aims are to: assist in meeting the operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

The purpose of this assessment is to outline some managed migration strategies for the South African DOH so as to increase the HR capacity in the public health care sector to deliver quality health care services, particularly to rural and other underserved areas. The recommendations of the assessment are envisaged to form the basis for subsequent information campaigns and related activities to complement the on-going work of South African local partners who recruit foreign health care professionals for the public sector.

The following section, **Section 2**, of the assessment provides an overview of health worker migration trends to and from South Africa with reference to "push and pull" factors and the overall migration dynamics of the region. **Section 3** examines the health care HR environment in terms of demand and supply, labour market conditions, and registration and visa requirements in each of the three northern countries – the Netherlands, the UK, and the US – and the in South Africa. **Section 4** identifies and maps the institutions and organisations in the Netherlands, the UK, and the US that address or could potentially address health care worker shortages in South Africa. **Section 5** sets out key findings and recommendations for addressing the current shortages in health care workers by: (1) retaining health care workers (and thereby decreasing the current emigration from the region); (2) promoting new internal migration flows of health care workers to address critical health care shortages in rural and other underserved areas; (3) attracting South African Diaspora health care workers back to South Africa (and in this way encouraging immigration); and (4) attracting other international health care workers from the three northern countries to South Africa. Three appendices provide specific proposals for encouraging the return of and new migration streams of health care workers, specifically from the Netherlands, the UK, and the US.

2. SOUTH AFRICAN HEALTH WORKER MIGRATION

The international migration of health professionals to wealthy European and North American countries and its negative effects on African health care systems are well documented. The World Health Report 2006 (WHO 2006a) describes Sub-Saharan Africa as having 11% of the world's population, 24% of its disease burden, including 69% of its HIV and AIDS cases, but only 3% of its health workforce. Actual stocks of workers also demonstrate acute shortages throughout Africa: the continent has 1.4 health workers per 1000 people compared with 9.9 per 1000 in North America (Mallaby 2004).

To ensure adequate coverage to attain the United Nations' (UN) "Millennium Development Goals", a density of 2.5 health workers per 1000 population is considered the minimum threshold level (Joint Learning Initiative 2004: 23-24). The provision of antiretroviral therapies requires even higher levels of coverage, whilst improvements in quality, efficiency, and new drug therapies could decrease these requirements (Ibid: 23). Even controlling for other factors (income, female literacy, poverty), increases in HR are associated with decreases in maternal, infant, and under-five mortality (with the strongest effects observed on maternal mortality) (Ibid: 26). Equally compelling is a direct correlation between the numbers of health service providers and antiretroviral therapy coverage rates (WHO 2006b:4). As WHO (2006b) notes, the health workforce crisis is creating a vicious downward spiral: with fewer health workers, disease prevalence rises, and as prevalence rises so too does the need for more health workers.

This migration of health care workers is precipitated by both "push and pull" factors between source and destination countries. In traditional economic terms, such flows are the result of individual decisions to maximise welfare (Dovlo and Martineau 2004). The interplay of "push and pull" factors leads to individual health workers' decisions to stay or migrate. These factors typically include disparities between source and destination countries in: salaries, social security and other benefits, job satisfaction, organisational environments, equipment, research opportunities, career and advancement, education and training, and protection and occupational risk (especially HIV-related risks). Specific "push" factors operating in source countries are: fear of crime; perceived and/or actual discrimination; issues of governance; and threats of or actual violence, war, and conflict. Specific "pull" factors in destination countries of Western Europe and North America are: the increasing demand for health workers with aging populations; recruitment strategies; and health care career structures that limit young entrants into the workforce but require large numbers of junior employees.

These decisions may nevertheless be moderated by "stick" factors in the source country and "stay" factors in the destination one (Dovlo and Martineau 2004; EQUINET No. 3). Stick factors, which predispose the person not to migrate include: family ties and loyalties; language and socio-cultural factors; national and historical loyalties; and land and property ties. Stay factors that encourage the migrant to remain in the destination country include: the costs of migrating again; a higher standard of living in that country; the desire not to disrupt children's schooling; mortgage payments; sense of security; and lack of good professional opportunities back home (Ibid.; Interviews in The Hague 2007).

Such analyses of "push"/"pull" and "stick"/"stay" factors are based on neoclassical economic analysis assuming that the individual migrant will maximise his or her economic utility (Bach 2006: 11). While this kind of analysis may be useful in illuminating determinants governing individual decisions, structural factors are equally if not more explanatory of major labour migration trends.

A structural analysis highlights the key role of macro-economic and political factors and how these may shift quickly to affect the directionality of various flows. Structural factors include labour wage differentials, political and social unrest, labour market discrimination, regulation of migration, and the role of structural adjustment policies leading to downsizing of the public sector workforce. Concurrently, trade liberalisation, relaxation of immigration rules, privatisation of health care, the professional training and development environment, shared linguistic and historical ties, and active recruitment schemes may shift various flows in one direction or another. These kinds of factors are more explanatory of massive flows of different categories of workers – e.g. flows of South African dentists to the Netherlands, South African nurses to the UK, or South African doctors to Western Canada. Structural analyses also suggest that these flows may be multi-directional in the face of globalisation, policy changes, and shifting economic requirements and may shift quickly. Such factors also explain conflicting and/or multi-directional flows. In both the UK and the Netherlands, for example, the numbers of doctors and nurses working abroad are rising even as the demand for foreign doctors and nurses there continues unabated (Bach 2006, citing Goldacre et al. 2001: 10).

Current debates about the "brain drain" or the "brain gain" are thus often highly over-simplified. Most countries adhere to the right of health workers to move freely and recognise the overall development benefits from such freedom of movement in terms of remittances

SECTION 2

and knowledge transfers. So-called “brain drains” could be viewed more positively as the circulation and transfer of knowledge. Given acute HR shortages and demands from HIV and AIDS morbidity and mortality, noted experts initially argued for regulating health care worker migration to address this crisis (Joint Learning Initiative 2004). Most now argue that such measures discriminate against professionals from poor countries, denying these health care workers the migration opportunities available to their counterparts from wealthy countries. Such regulation has also created incentives for health workers not to practise and/or to shift professions.

Facilitating migration flows to address specific health care shortages has been shown to mitigate the adverse effects on losses of skilled personnel. Some countries, notably the Philippines, Cuba, Iran, and India, actively promote and train health care workers for migration and derive remittances from this labour migration source.¹ Such flows may also be temporary and, in the long run, provide benefits to countries of origins. Several studies, for example, suggest that nurses may remit more earnings than doctors and are more likely not to migrate permanently (studies cited in Dovlo and Martineau 2004; Interviews in the Netherlands 2007 and the UK 2006). Diaspora doctors from Ghana and South Africa, however, are also volunteering time, expertise, and equipment to train workers in their countries of origin. In addition, many other health care personnel in developed countries are willing to volunteer their time and services for periods of time to gain new skills and experience (Institute of Medicine 2006; Crisp 2007). Countries are therefore evaluating ways to encourage short-term, temporary, virtual migration schemes that increase skill levels and remittances in ways that eventually benefit public health systems and, in some cases, encourage permanent returns.

Obtaining accurate data on global migration flows has been inherently difficult and, as noted earlier, the directionality of labour migration flows may change quickly. Without accurate information on flows, it is difficult to determine costs and benefits of a particular movement. For example, there may be benefits from circular, temporary migration that should be encouraged, whereas having a well trained African doctor working as a taxi cab driver in London is clearly a loss for both medical systems. Most countries do not record entries and exits of particular professional groups. The most accurate estimates are based on professional registration and licensing (but these indicate only the intent to practise, at best). These data on stocks of different international registrants also do not reveal the direction or destination of flows nor indicate the characteristics of the migration flow (whether permanent, temporary, long term or short term, circular, periodic, etc.). There is clearly a need to monitor stocks and to derive more information about migrant intentions and flows over time in order to develop cost-effective, targeted interventions.

Recent analyses further demonstrate that the majority of the losses of health care personnel in particular markets are from the public to the private sector, both internally and internationally. Labour migration is becoming increasingly privatised and, therefore, even more difficult to track. Private health care providers are also reluctant to share their recruitment strategies and/or indicate specific openings for fear of losing out to the competition (Interview in the UK 2007). In addition, skilled health care personnel are being lost to development projects, which often pay higher than the local market rates (Interviews in the US 2007; Bach 2006).

Significant health care worker losses are the result of HIV and AIDS morbidity and mortality. HIV and AIDS pose not only specific increased occupational risks to health care workers but also lead to fatigue and desperation with dealing with AIDS-related and other diseases, often without the necessary counselling, support, and infrastructure. Other communicable (and non-communicable) diseases are on the rise in Southern Africa and the lack of resources and equipment to meet client needs and demands further accounts for loss of personnel from the public to private sector, from rural to urban areas, and from one country to another.

Given the complexity of factors leading to health worker shortages, addressing long-term health care shortages is not likely to be easily resolved by restricting migration opportunities. Even though migration is often touted as a significant contributory factor to Africa’s health care worker shortages, facilitating migration flows may also be part of the solution. In assuring the availability of high-quality health care worldwide, participants at the IOM International Dialogue on Migration seminar, “Migration and Human Resources for Health: From Awareness to Action” (2006: 18) observed three considerations that need to be taken into account in the development of any migration strategy: (1) the international mobility of persons, as an integral part of globalisation, is here to stay; (2) everyone has the right to leave any country, including his/her own; and (3) migration is a potentially beneficial feature of the modern world. Attracting people to move to and work in the areas where need is the greatest is obviously a question of creating the right incentives and support. Encouraging different forms of migration and exchanges may also provide the needed resources, energy and commitment to address the critical morbidity and mortality associated with HIV and AIDS and other diseases.

1. Since 1960, over 67,000 Cuban public health professionals have served in 94 countries and more than 9000 students from 83 countries have been trained in Cuban medical schools (Joint Learning Initiative 2004:110). India and the Philippines are also major source countries for doctors to the US, Canada, and the UK (Ibid: 5).

2.1 SOUTH AFRICAN HEALTH WORKER MIGRATION

In a ranking of countries worldwide, South Africa is classified in the global distribution of health personnel as having a moderate distribution, as opposed to a low distribution. South Africa is also categorised as being in the low density-high mortality category of personnel in relation to need (Joint Learning Initiative 2004: 159). In contrast to Ghana or Malawi, which are first-tier countries, for example, South Africa's health care shortages are seen as less of a priority than those of other African countries whose needs are even more acute. Nevertheless, South Africa's high documented HIV and AIDS prevalence suggests that the country's actual requirements for various kinds of health care personnel may still be amongst the highest in the world.

The scale and rate of South African migration has increased in recent years both to and from the country. South African doctors emigrate at a rate of about 1000 annually (Mallaby 2004: A19). In 2003, South Africa had some 4000 vacancies for doctors in the public health sector alone (Hamilton and Yau 2004: 3). Since South Africa pays for health training through its public medical schools, the financial losses incurred by the country when doctors and nurses leave are considerable – an estimated \$1 billion a year (Hamilton and Yau 2004: 3). Official financial losses from the migration of South African doctors between 1989 and 1997 are estimated at \$5 billion (Dovlo and Martineau 2004: 5). The aggregate loss of 600 South African doctors to New Zealand alone was estimated at R600 million (Ibid citing Padarath 2003).

Amongst the OECD countries, only Australia and the UK number South African doctors in their top three countries of origin. South Africans comprise 9.7% of total foreign-trained doctors in Australia and 7% of those in the UK (cited in Bach 2006: 4). Overall, the proportion of foreign-trained doctors was 21.4% (2001) of all doctors in Australia and 12.6% (2001) of all those in the UK (Ibid). The top four countries of destination – the US, Canada, New Zealand, and Australia in that order – have a total of 6993 South African doctors registered in their respective workforces, representing 18.53% of a total of 30,740 registered physicians in South Africa (Mullan 2005).

In 2000, DENOSA reported 2543 applications of nurses applying to do nursing work in another country, with the main destination countries being the UK, Saudi Arabia, New Zealand, and Australia (Buchan, Parkin, and Sochalski 2003: 48). In 2002, DENOSA predicted that more than 300 specialist nurses were leaving the country every month (EQUINET n.d., 3.3.). By 2003,

South Africa reported 32,000 nurse vacancies (Hamilton and Yau 2004). Nevertheless, as noted earlier, nurse migration is usually less permanent than physician migration. Nurses are more likely to leave families behind and are not as tied to a career track in a particular place (and, therefore, can more easily be re-employed back home) (Ibid; Interviews in London 2006).

Even as South Africa is losing skilled health workers, the country is also the major destination for skilled health care workers from other parts of Africa. South African salaries in comparison with those of other African countries make it a magnet for doctors and nurses throughout the continent but especially, most recently, from Zimbabwe, the DRC, Nigeria, Botswana and Ghana. Amongst all the countries in Africa, South Africa has the highest physician and nurse coverage: 56.3 physicians and 471.8 nurses per 100,000 population, in comparison to the DRC, for example, with 6.2 and 44.2 respectively.

Recognising its impact on other markets, South Africa declared a moratorium in 1996 on the registration of all foreign doctors with the Health Professional Council. This moratorium was eventually lifted but the South African Government maintains an official policy of not issuing any visas to health professionals from developing countries.² Nevertheless, migration experts suggest that illegal immigration of health personnel is continuing (Interviews in the US 2007). Health care personnel are also being attracted by possibilities for employment in the private sector. Thus, addressing some of South Africa's demand for health care workers from other countries could potentially alleviate health personnel challenges faced by neighbouring countries with more acute HR shortages as well. Members of the Rural Doctors Association of South Africa (RUDASA) have also argued and lobbied strongly for restricting migration from other resource-poor countries whilst encouraging migration from Northern countries.

South Africa has addressed some of its HR shortages in the public sector through "importing" Iranian and over 300 Cuban doctors to work in rural areas.³ Medical experts note that the Cuban doctors (who have been "exported" around the world for over two decades) have the necessary training and skills to adapt well to rural health conditions (Joint Learning Initiative 2004). At the same time, cultural and linguistic difficulties are reported (Interviews in the UK 2007). Another problem has been in ensuring that these doctors receive regular salaries that they do not then have to turn over to the Cuban Government (Interviews in the US, the Netherlands, and South Africa 2006 and 2007).

In the immediate lead-up to the end of apartheid and after the 1994 elections, there was an outflow of white South Africans,

2. Given identified shortages, this policy is primarily enforced in the public sector (interviews with immigration lawyers and Ministry of Labour officials in South Africa 2006).

3. China and the Philippines are also being considered as other potential source countries.

whereas during the apartheid period, both black and white South Africans fled the apartheid regime. The post-apartheid outflow has been primarily for economic and professional reasons whilst the earlier outflow contained a large number of those who left for political reasons. The particular circumstances underlying one's exit continue to distinguish different Diaspora affiliations and alliances of medical professionals, where they have settled, and their propensity to return (Interviews in the UK and the Netherlands 2007). Most doctors who left during apartheid have established careers in Western Europe and the US. Those who have left more recently are more likely to have settled for economic reasons in North America, Australia or New Zealand (Interviews in the UK 2006, and in the US and the Netherlands 2007; Mullan 2005).

Those who left many years ago for political reasons are less likely to return permanently but report being willing to provide technical assistance, training, and scholarships. Those who left more recently may be willing to return on a short-term or permanent basis if they believe that there are new economic possibilities and opportunities. Nurses, as a group, are more likely to return than doctors since their skills and career paths are more portable (Interviews in the UK and the Netherlands 2007). In the late 1990s, efforts to downsize the public sector led to many nurses being given incentive packages to leave and they were initially encouraged to find work in the UK (Interviews in the UK 2006). Only a few years later, there would be acute shortages in the nursing sector. Today, South Africa is both a migration sending and receiving country for health professionals of all categories.

2.2 Migration of South African Health Care Workers to and from the Netherlands

The migration of nurses and doctors from South Africa to the Netherlands diminished considerably with the adoption of the Memorandum of Understanding (MOU) for Health 1997, 1998, and 1991 (Interview with the Department of Health 2007; South Africa, Department of Foreign Affairs 2005). The Intersectoral Planning for Health in the Netherlands 2000 early on promoted addressing the country's own health care shortages through expanded training (Haslinghuis 1987). The MOU for Health 1997, 1998, and 1991 restricted the recruitment of health care personnel to the public health sector in the Netherlands (Interview with the Department of Health 2007). Since all major Dutch medical and health care institutions are public, the Netherlands-South Africa MOU could be enforced across the board. The MOU was also adopted in part after a group of recruiters brought a group of doctors to the Netherlands and then left them adrift to work out their own employment (Interviews in the Netherlands 2006 and

2007).⁴ Although the MOU is no longer in force, active recruitment has virtually stopped and South African health care workers have difficulty obtaining the right work in the Netherlands, given the general restrictions on migration from outside the EU.

In 2000 and 2001, a total of 461 new doctors registered from outside the EEC and, by 2005, only 95 (Department of Health interview; BIG Register). In 2001, there were 529 new registered nurses from outside the EEC and, by 2005, only 33. These declines reflect a national policy of reducing migration over the past few years. The actual number of those practising may be lower than those registered in the Netherlands since South African doctors are then attracted away to the UK market. Prior to 2006, coming from a Commonwealth Country, they were often exempted from having to register again in the UK. The UK General Medical Council (GMC) rules have tightened and South African doctors, even if they have already registered in the Netherlands, are likely to be treated in the same way as other doctors coming from outside of the UK (BMA advice; BMA and GMC 2006).

Dutch Government officials observe that even the minimal recruitment of South African nurses and doctors to the Netherlands has been very mixed and, in some cases, has had quite negative results. An initial group of nurses from South Africa was posted to a university hospital in Amsterdam. They were issued temporary permits but several tried to remain (and/or may have left for the UK). Many also ended up working in nursing homes and in jobs that did not utilise their skills. In 1999-2002, the "Care Medical Specialists' Foundation", a recruitment agency, brought in 36 doctors and nurses without work permits. With large nursing shortages during that period, the Dutch authorities did not monitor the situation carefully. A scandal ensued and the majority were left adrift to negotiate their own placements.

With more restrictive migration policies in the Netherlands, most South Africans have difficulty in obtaining work permits and the trend has been downward. In 2005, a hospital in The Hague brought in over 80 South African nurses, who were issued permits. That same year, a total of 90 South African health workers were issued permits (of which the other ten could have been renewals). In 2006, a total of 70 work permits were issued to South Africans of all professions, of whom 18 were health workers. Even amongst those 18, several may have been renewals. Currently, it would be very difficult for any South African health worker to obtain a work permit outside of a formal exchange programme.

In dentistry, there is still some migration and demand from South Africa to the Netherlands. As a young South African dentist observed, of 50 students in his graduating class of 2005, at least six or seven now practise in the Netherlands. Nevertheless,

4. The recruitment of a group of Filipino nurses for a temporary period was also not successful in that the nurses were placed in elderly-care establishments when they expected to be working in hospitals.

dental practices are more privatised and most – if not all – of these permits would be obtained through private practices.

2.3 Migration of South African Health Care Workers to and from the UK

The movement from South Africa to the UK is strongest for nurses. Between 1998 and 2005, 9249 South African nurses registered in the UK. The peak year for registration was 2001/2, with 2114 nurses, and the trend has been downward since then. South African nurses are also a major group among foreign-registered nurses in the UK. In 2004/5, there were 933 new nurses of South African origin admitted to the registrar. Overall, there has been a 44% decrease in admission since the peak in 2001/2002. However, there was a slight rise in admissions between 2002/3 and 2003/4, which suggests that there is still some flux in these movements. The increases during those years also suggest the willingness of the South African Government to allow such migration.

The UK has developed a centralised set of policies and management system for HR in its public health sector. Therefore, specific international agreements to which it is a signatory are enforced across the public health sector. The Department of Health (DOH) “Guidance for International Nurse Recruitment” (1999) and its “Code of Practice for the International Recruitment of Health Care Personnel” (2001) had a major impact in ensuring that National Health Service (NHS) employers no longer engaged in the active recruitment of health care personnel from South Africa or any other countries with health care worker shortages. With the “Code of Practice”, the UK NHS agreed that, unless there was a specific MOU with another country, it would not take health workers from countries with shortages and would also suspend contracts with private firms recruiting from them.

From 2000 onward, this Code substantially slowed down recruitment from South Africa to the public sector while recruitment from India and the Philippines increased, these being two countries with which the DOH signed MOUs in the form of inter-governmental co-operation agreements to encourage exchange of health care personnel, information, and guidelines. Both the Philippines and India, as noted earlier, have developed explicit strategies to train surpluses of doctors and nurses to work abroad.

In May 2002, 53 Commonwealth health ministers also signed the Commonwealth Code of Practice for the International Recruitment of Health Workers in which they agreed to adhere to three core principles – “transparency” in recruitment between origin and source countries; “fairness” in terms of not recruiting health workers with outstanding obligations to their countries and of offering the same conditions as workers in the destination

countries; and “mutuality” of providing technical assistance and considerations of other forms of compensation to source countries (Commonwealth Secretariat 2002). The Code of Practice is not a binding legal document but provides a framework for governments within which international recruitment should take place.

With the signing of an MOU between South Africa and the UK “to facilitate the reciprocal educational exchange of healthcare workers and concepts” (Crisp 2007: 96), there is now a downward trend in UK Nursing and Midwifery Council (NMC) figures for registrations of nurses and midwives from South Africa. The UK Department of Health uses these registrations as a proxy indicator to measure the success of the “Code of Practice for International Recruitment” (Commonwealth Secretariat 2002; Interview with the Department of Health 2006). The fall in registrations also reflects the greater self-sufficiency on home-trained nurses.

Another reason for the decline is that the UK immediately qualifies nurses and midwives who are citizens of the EU or European Free Trade Area (EFTA). All foreign nurses – whether from the EU or elsewhere – must register with the Nursing and Midwifery Council (NMC) unless they plan only to work in the UK temporarily. For those outside the EU, the NMC is experiencing delays in processing overseas registrations, although it aims to process all registrations in 135 days (FAQ 2006).⁵ Applications are considered on the basis of education, training and registration outside the UK, as well as the ability to communicate effectively in English. For those outside the EU (or EFTA), applications are considered on an individual basis. However, South African nurses with recognised training are usually registered quickly (FAQs 2007).

South Africans constitute the third major group of Diaspora doctors in the UK after those from India and Pakistan (or the fourth if Ireland is also included). There are currently 1980 registered physicians from South Africa in the UK (Mullan 2007). A total of 1980 South African doctors were registered in the UK in 2005, representing 1.4% of the physician workforce (Mullan 2005: 1812).

Since 3 April 2006, the UK Department of Health has required International Medical Graduates (IMGs) – who are not UK or European Economic Area (EEA)⁶ nationals – wishing to work or train in the UK to obtain a work permit. To obtain a work permit, an employer must also show that a genuine vacancy exists, which cannot be filled by a doctor who is a UK or EEA national. All foreign doctors must then register with the General Medical Council (GMC) to sit an English Language Test and two “Professional Linguistic Assessment Boards” (PLAB I and 2).

5. See http://content.healthcare.monster.co.uk/6076_EN-GB_p2.asp for detailed explanation of registration of international nurses in the UK.

6. The EEA was established in 1994 and is concerned principally with the four fundamental pillars of the internal market, “the four freedoms”; i.e. freedom of movement of goods, persons, services and capital.

Despite the tightened regulations for registration, many doctors still first migrate to the UK, where they obtain their necessary licensure, and then subsequently migrate to North America (Canada or the US) (Interviews in the UK 2006, 2007).⁷ The exams are not a serious obstacle for most South African trained doctors because of the level of training they receive and the similarities between the two medical systems. In addition, doctors from Anglophone countries have a definite advantage on the English test.

2.4 Migration of South African Health Care Workers to and from the US

Between 1997 and 2000, South African and Nigerian nurses accounted for 7.4% of the 26,506 applicants for nurses'

7. This observation was also confirmed in British Columbia, Canada and Washington, D.C., US, in conversations and interviews in 2007.

licensures in the USA (Dovlo and Martineau 2004: 4). Some 2006 South African doctors are registered in the US, and South Africa ranks 23rd amongst countries supplying doctors to the US and is first amongst African countries after Nigeria (Mullen 2006). Nevertheless, for South African doctors, the US with its high salaries, technologies, and specialised training is still a destination of choice and the largest number of International Medical Graduates (IMGs) registered overseas is found in the US, followed by the UK, Canada, and Australia (Ibid). Dentists are also reported to migrate to the US in large numbers, primarily to set up private practices, but because the US registration system does not record nationality, no data were available (Interviews in the US 2007).

3. HEALTH CARE HUMAN RESOURCES ENVIRONMENT IN SOUTH AFRICA, THE NETHERLANDS, THE UK AND THE US

3.1 South African Resource Needs and Constraints

Health care personnel are not only disproportionately distributed between rich and poor countries; they are also mal-distributed according to need, with an increasing number moving from the public to private sector, from rural to urban areas, and from primary to tertiary levels of the health care system. As the Regional Network for Equity in Health in Southern Africa (EQUINET) observes, the inequitable distribution of health care personnel towards the private sector is more pronounced in South Africa, where the private sector is more highly developed, comprising thousands of doctors, private laboratories and pharmacy distribution companies. In all, private-sector providers represent approximately 50% of South Africa's health care capacity. In 1999, 73% of general practitioners were working in the private sector even though this sector covered less than 20% of the population (EQUINET n.d., sec. 2.1).

It is also documented that South Africa has 35,000 either inactive or unemployed nurses, despite the 32,000 public-sector vacancies (Hamilton and Yau 2004).

Of all the countries in Sub-Saharan Africa, South Africa has the highest proportion of "private-for-profit" providers. The private sector represents 58% of total health care expenditures and captures a higher proportion of all health care providers than the public sector, except in the case of nurses (EQUINET n.d., 2.1).

The private sector also plays a major role in draining doctors, nurses and other health care professionals from the public sector. Its advantages and attraction are better salaries, improved working conditions, increased possibilities for advancement and mobility (both domestic and international), and streamlined and responsive institutional procedures and regulations. There are four major private medical groups in South Africa: Netcare, Medi Health, Thebe MediCare, and Medi-Clinic.

For example, the Medi-Clinic Group, founded in 1983 in Cape Town and listed on the Johannesburg Stock Exchange in 1986, commands 23% of the market share of the private healthcare industry. Medi-Clinic has nearly 6400 beds and 12,000 full-time employees servicing more than 50 hospitals countrywide and in Namibia. Medi-Clinic is also expanding its reach and services, opening clinics throughout the UK. In December 2002, Medi-Clinic acquired the Curamed group of private hospitals in Pretoria, in association with the black empowerment group Mvelaphanda. In 2005 Medi-Clinic acquired Wits Donald Gordon Medical Centre and Legae Private Hospital in the Tshwane region.

3.2 Quantity/Quality of Supply, Labour-market Conditions and South Africa Diaspora in the Three Countries

The supply of health care workers for potential recruitment to South Africa varies according to each country's migration and

recruitment policies; labour-market patterns, regulation, and requirements; and the size and role of the Diaspora community in each country. This section discusses the potential sources of supply and specific health programme and projects that provide or could provide health workers to South Africa.

3.2.1 SUPPLY, LABOUR MARKET AND DIASPORA IN THE NETHERLANDS

The Netherlands Ministry of Health does not encourage any health workers to go abroad since it foresees that in the coming years, despite the expansion of the EU, the Netherlands, with an aging population, will experience increasing shortages of health care professionals. As an official observed: “It would be against our own national interest to encourage our doctors and nurses to work abroad”. Nevertheless, the same official noted that there would not be any restrictions put on doctors and nurses and there could be some benefits overall from temporary postings.

There is also a very strong tradition and supply of doctors and nurses interested in working abroad (Interviews in the Netherlands 2007). According to several doctors and nurses interviewed, recent Dutch medical graduates of between 25 and 30 years of age are often willing to volunteer for two to three years; whereas those 55 years and older are willing to volunteer for longer periods of time. Many doctors and nurses are willing to go abroad to enhance their scope of practice.

In the Dutch medical system, both doctors and nurses are expected to be increasingly specialised but, over time, their work also becomes increasingly narrow in scope. For this reason, after 25 to 30 years in the same line of practice, many seek a way to broaden their skills and expertise. Most would prefer to go to a developing country (versus a developed health care market such as South Africa’s) because they are immediately engaged in and allowed to work on a broad spectrum of health care issues. Recent graduates, particularly those with tropical and infectious-disease specialties, are also prepared to go for three to four years because they perceive the experience as useful for their speciality. There is also a dedicated group of Dutch surgeons who are willing to go for short periods of up to three weeks to provide training and/or specialised operations to address particular shortages.

Given their common language background, the Diaspora that has settled in the Netherlands is generally of Afrikaner origin. A number of black South Africans also sought political asylum in the Netherlands during the apartheid era and have made their life there. For various political and cultural reasons, many are reluctant to leave – at least in the near future. The number of first-generation South Africans living in the Netherlands only totals 8129, making them the 19th largest ethnic minority (Government of the Netherlands, Ministry of Foreign Affairs 2004: 82).

3.2.2 SUPPLY, LABOUR MARKET AND DIASPORA IN THE UK

Since 1997, the UK has increased its investment in the education and training of nurses/midwives. By 2004-2005, this had led to a 67% growth in the number of candidates entering nursing and midwifery. The UK DOH currently argues that it meets its needs locally, through supplies of health workers from the new EU countries and from its MOUs with two countries – India and the Philippines. According to a UK DOH policy analyst, other countries, including South Africa, would like to sign MOUs with the UK to derive the benefits of remittances and training but that it currently does not have a need to recruit elsewhere. With cost-cutting measures, the NHS is also downsizing some of its personnel, particularly in administration.

In 2003, the South African Ministry of Health decided to organise a number of time-limited opportunities for South African nationals overseas, believing this to be of benefit to both the individual and the home country. According to the UK DOH, countries such as South Africa recognised the benefits of such exchanges but, with pressures to cut costs, the UK DOH has been reluctant to sign further MOUs. In recent years, to cut costs, an increasing number of NHS services have also been contracted out to private firms. Some of the primary beneficiaries of such contracts have been the major South Africa private-sector firms. The UK DOH has signed an MOU with the South African Government. Nevertheless, this MOU does not cover the private sector nor does it explicitly cover private-sector contracts with the public sector.

Although private contractors are also bound to observe the “Code of Practice” in their hiring procedures in providing NHS services, doctors and nurses from English-speaking countries routinely find employment in other private-sector services (e.g. nursing homes and retirement homes). Once registered and with residence permits, these doctors and nurses often transfer to the public- or private-contracted service delivery system. The advantage for the NHS and its private providers is that these health care workers are fluent in English and have similar training to that provided by the UK system. The doctors, for example, easily pass the English test and three qualifying exams required to be licensed in the UK and are hired as general practitioners (at lower levels) and paid less than British-trained doctors (Mensah personal communication 2007).

The lack of health care workers in developing countries has a high policy profile. Former Prime Minister Tony Blair requested Lord Nigel Crisp, the former Chair of the NHS, to review how the UK’s experience and expertise in health care could benefit developing countries to address such shortages. Lord Crisp’s ensuing report, “Global Health Partnerships” (Crisp 2007), argues for a variety of health partnerships, including private and government exchanges, Diaspora returns, and international internships, education, research and training and the establishment of a global health

partnership centre (as a one-stop-shop source of information). Established in 2006, the government's Inter-Ministerial Group on Health Capacity in Developing Countries⁸ has been given responsibility for implementing the Lord Crisp Report findings. As part of its response, the government has also committed GBP one million over the next two years to assist the Global Health Workforce Alliance in finding solutions to the lack of health care workers in poor countries. Nevertheless, while supporting many of the conclusions of the report, during recent hearings of the House of Lords, Baroness Royall of Blaisdon observed:

While we want doctors to work abroad, we also want to ensure that that does not have serious repercussions for our own health services and that the doctors' careers are enhanced when they undertake such missions. On the issue of doctors in developing countries, we want to assist them to stay in their countries where that is possible (UK House of Lords, 2007).

The South Africa Diaspora in the UK also has its own interests and motivations, which are not well reflected in the current debates. For example, the Association of South African Nurses in the UK meets twice a month and has an active membership ranging from some 500 to 1000 nurses. This group has many members that are actively interested in returning to South Africa and they have held meetings with Homecoming Revolution and MediCare about return options. According to one of the chief organisers, a "significant" number (perhaps a few hundred) of nurses have spent several years in the UK and would now like to return to their families and work again in South Africa (Interviews in the UK 2006).

To date, return migration of health care workers is still limited to a few initiatives and individual decisions (as opposed to a massive flow). MediCare has returned 60 South African nurses to fill slots in its own health care institutions but has a demand for more than 2000 nurses and doctors.

3.2.3 SUPPLY, LABOUR MARKET, AND DIASPORA IN THE US

US official health care policies are not centralised since the health care system is highly privatised and largely financed through private insurance companies and health management organisations. However, the creation of the President's Emergency Plan for AIDS Relief "PEPFAR" has created a centralised system in terms of addressing health care worker shortages due to HIV and AIDS. The US Government commissioned a Committee of Experts of the Institute of Medicine to investigate "Options for Overseas Placement of US Health Professionals"

(Institute of Medicine 2005: 1-2).⁹

In their ensuing study, "Healers Abroad" (2005), the Institute of Medicine's Committee recommended the creation of a Global Health Service that would implement six programmes: (1) a Global Health Service Corps; (2) Health Workforce Needs Assessment; (3) a Fellowship Programme; (4) a Loan Repayment Programme; (5) a Twinning Programme; and (6) a Clearing House. As in the UK, there is domestic ambivalence about encouraging doctors to go abroad, given perceived health care shortages at home. The House Judiciary Committee approved the Bill, HR 4997, which provided a "Waiver of Foreign Country Residence Requirement with Respect to International Medical Graduates" and was passed by voice vote on 16 March 2006. This programme allows foreign physicians who receive medical training in the US and practise in medically underserved areas to remain in the nation for three years. However, the African Health Capacity Investment Act of 2006, which was introduced in the Senate to improve human health care capacity and retention of medical health professionals in Sub-Saharan Africa, was not passed in the last Congressional Session (S 3775). In contrast to the earlier bill, this Act would have promoted voluntary codes of conduct for recruiters, expanded training of US health personnel to cover its own shortages, and provided assistance to the health sector in Sub-Saharan Africa to address health sector human capacity issues. Nevertheless, members of the Institute of Medicine Committee suggested that similar bills were likely to be proposed in both the House and Senate this legislative year, including efforts to promote a Global Health Service (Interviews in the US 2007).

In the early assessments of PEPFAR in 2004, the Council on Foreign Relations and the Milbank Memorial Fund, while noting PEPFAR's strengths, specifically criticised its under emphasis on infrastructure, human capital, and testing and over emphasis on services designed to deliver antiretroviral therapy, in this way creating parallel structures and draining resources away from other areas of the health system (reported in Institute of Medicine 2005: 71-2).

In July 2006, the US Senate called upon the Office of the US Global AIDS Coordinator to submit a report on the additions in health care workforce capacity required and the Coordinator's strategy for meeting shortfalls in health workforce capacity. The Global AIDS Coordinator's Report (PEPFAR 2006: 6) noted that

Six of the 15 PEPFAR focus countries in Africa – Cote d'Ivoire, Ethiopia, Mozambique, Tanzania, Uganda, and Zambia – do not meet the WHO "Health for All" standard of one medical doctor per 5,000 population; four others – Botswana, Namibia, Nigeria, and South Africa – just meet the standard.

8. The Inter-Ministerial Committee includes representatives from the Department of Health, Department of Education and Skills, HM Treasury, Foreign and Commonwealth Office, Home Office, DFID, Northern Ireland Office, the Scottish Executive, and the Welsh Assembly (Crisp 2007: 67).

9. The Committee was instructed to review available data sources to project the optimal size of a US global health service, assess existing models, articulate principles for evaluation, and examine contextual issues related to implementation of a service programme (Institute of Medicine 2005: 2).

In 2006, PEPFAR's "Emergency Plan Response" invested an estimated \$US 350 million on health workforce and systems development (representing 25% of PEPFAR field resources for prevention, treatment and care in focus countries) (PEPFAR 2006: 7). Such support must be requested within national plans and priorities and may include support for: policy reforms to promote task-shifting from physicians and nurses to community health workers; development of information systems; HR assessments; training support for community and other health workers; retention strategies; and twinning partnerships (Ibid: 7). Of the PEPFAR-funded HR interventions, to date, the only South African intervention noted in the report is the training of Persons Living with HIV' (PLWH) organisations and members to act as community health workers to provide care, staff clinics, and monitor antiretroviral treatment (Ibid: 11).

Nevertheless, the US Government is also providing technical assistance and personnel for HR issues in South Africa through the US Department of Health and Human Services/Health Resources and Services Administration, Centers for Disease Control, USAID-funded projects and National Institutes of Health. Two USAID-funded projects providing twinning/exchange programmes in South Africa include I-TECH, a collaboration of the University of Washington and University of California, San Francisco, and the American International Health Alliance (Ibid: 78).

Within the US, there is significant private-foundation and private-sector involvement, interest and proposals for addressing the health care resource issues generally in South Africa. For private foundations, such as the Bill and Melinda Gates Foundation, the HR shortages are recognised as a major constraint to address HIV and AIDS, malaria, and tuberculosis. Virtual and technical networking projects through the Internet and cellular phones are being trialled in South Africa (Institute of Medicine 2005: 199). US corporations working in Southern Africa have also developed workforce HIV and AIDS prevention programmes and several major drug companies provide reduced-cost or cost-free drug programmes (notably Merck, GlaxoSmithKline, and Bristol-Myers Squibb) (Ibid: 81). The Pfizer Global Health Fellows programme provides Pfizer employees with medical and management expertise to assist leading international NGOs.

Numerous private and/or small religious or faith-based US NGOs emphasise training and/or increasing human resource in their HIV and AIDS work (much of which has also been funded through PEPFAR) (Ibid: 83). Nevertheless, an Institute of Medicine survey found that most NGOs with budgets of between \$US 100,000 and \$US 1.5 billion focus on sending doctors and nurses (as opposed to other needed health care personnel) for periods of less than two months. The survey also identified partnering challenges, lack of supervision, high turnover of local staff, and negative reactions to the placements (amongst other challenges noted) (Ibid: 83-84).

Within the US, there is still a surprising lack of discussion about encouraging Diaspora involvement or returns. In the case of South Africa, its Diaspora community in particular is quite dispersed and health care workers within this community were not reported to have specific professional organisations that meet regularly. Amongst US Diaspora communities, African foreign born comprise only 3% of the 33 million foreign born in the US in 2002; and of the African foreign born, only 6.9% (71,883) came from South Africa (Greico 2004: 2). To the extent that the South African Diaspora is organised in the US, most of the organisations centre around South Africa-US chambers of commerce (Interviews in the US 2007).

3.3 Key Legal/Social/Political Requirements and Constraints

The particular legal, social, and political environment in each country creates certain opportunities for and constraints on the return of Diaspora health care workers and/or short- or long-term migration of other health care workers to South Africa. Certain legal, social, and political requirements within South Africa also constrain Diaspora returns (regardless of colour or ethnicity).

From the perspective of the Diaspora in all three countries, health workers particularly amongst white upper-middle-class migrants reported that a major constraint to their returning is the continuing high rate of crime in South Africa and, specifically, the murder rate (Dovlo and Martineau 2004: 33). One Diaspora dentist brought with him to the interview with the author "Crime Statistics for South Africa (1994/1995 to 2003/2004)" that he tracks regularly. Although the murder rate declined during this period from 25,965 to 19,824 per annum, he saw the absolute levels as too high. Those who had moved their families abroad stated that they were reluctant to return until "law and order are restored" (Interviews in the Netherlands and the US 2007).

Other major concerns that the Diaspora express about returning are "falling standards" and "affirmative action" (Interviews in the UK, the US, and the Netherlands 2007). Such concerns suggest the value of staged returns, which would allow the Diaspora to test out these concerns and assumptions directly. The Diaspora could be encouraged to invest, first, at a distance and, then, to make temporary and periodic returns before having to make any commitment to a permanent return.

These same concerns do not deter potential migrants from the Netherlands, the UK, and the US from emigrating temporarily or permanently. According to health professionals from the US and the Netherlands, most volunteers who are willing to serve for one or two years are not deterred by crime or security considerations. As one nursing director observed: "nurses interested and willing to work abroad are already risk takers". Health professionals in

all three countries, however, note that, outside of those working on HIV and AIDS-related issues, South Africa is not considered a priority country of need, especially in terms of emergency and humanitarian support. According to the same nursing director, for such programmes to be saleable, nurses need, in general: (1) easy regulatory mechanisms for their licences; (2) occupational health and safety assurances (at least recognised as an important issue to be addressed); and (3) a living wage – not at international levels but at local levels.

Dutch foreign doctors are willing to work abroad but generally expect a fair local equivalent salary and compensation package (Interviews in the Netherlands 2007). They also suggest that there should be some reasonable comfort level. A Dutch programme in Sierra Leone, for example, builds and buys good guest houses for its medical teams and the free rent provided is then deducted from the local compensation package. Likewise, Rural Health Initiatives (RHI) has found that it needs to assure good housing for its placements in rural areas in South Africa. Both RHI and the Dutch doctors working abroad also stress the importance of providing comfortable and safe accommodation and good communication and Internet facilities, particularly for anyone staying more than two to three weeks.

A particular constraint for Diaspora health care personnel returns from all professions is a widespread perception that they are not welcomed back (Interviews in the UK, the US, and Netherlands 2007). Although Deputy President Phumzile Mlambo-Ngcuka has explicitly welcomed their return, Diaspora health professionals in all three countries cite earlier public rhetoric and pronouncements to the contrary as evidence that they are not wanted (and in the case of white South Africans, statements to the effect that they are regarded as “cowards” for leaving and are not wanted back). Several Diaspora noted that such reluctance is played out in the difficulties and time delays they encounter in re-regularising their immigration status and/or in being employed again in the public sector (interviews in the UK, Netherlands and US 2007). Such delays in obtaining work permits and residence visas are also reported to deter other health care workers from going to South Africa.

In addition, a few hundred black South African nurses working in the UK are committed to returning to their families who have remained in South Africa. However, because they earlier took a severance package to encourage them to leave the public sector during the late 1990s, they are prohibited from again working in the public sector. During this earlier period, South Africa was offering incentives to downsize its public health sector. According to one of the leaders of the South African Nursing Association in the UK, many nurses would prefer to return and work in the public sector, where the work is said to be more varied and requires a greater degree of responsibility than most private-sector employment,

but currently the government requires that readmission to the public sector be negotiated on a case-by-case basis.

3.3.1 THE NETHERLANDS LEGAL/SOCIAL/POLITICAL CONTEXT

The Netherlands allows for dual citizenship and transferability of pension rights. The first generation migrants retain strong ties with South Africa and most reported that they would go back eventually – if not immediately, then upon retirement.

In terms of medical requirements, Dutch medical schools and institutions are more favourable towards and used to health care professionals doing two- to three-year internships or placements abroad than their counterparts in other European countries (Interviews in the Netherlands 2007). Working abroad is viewed as advantageous, particularly in the beginning or at the end of one’s career. Nevertheless, increasing shortages in the nursing sector (and especially with the aging population) may discourage such practices in the future.

The Netherlands has a long history and tradition of supporting health care workers to spend time in other parts of the world. An advantage that Dutch doctors and nurses have in working abroad is that it is not unusual for one’s institution to support a two- to three-year assignment in another country.

The South African Diaspora is primarily organised through SANEC, a South African Netherlands trade organisation and this group holds regular events and meetings that keep its membership in contact with South Africa. The South African Embassy also keeps lists of South Africans living in the Netherlands who are willing to register and to list their occupation with the Embassy. The South African Diaspora, however, is not a defined community but several communities of overlapping interest.

3.3.2 UK LEGAL/SOCIAL/POLITICAL CONTEXT

There are few constraints and no legal requirements for Diaspora returns from the UK. Return migrants with British passports are allowed to maintain their citizenship and they also have access to pensions. Socially, the difficulty reported most often is that many Diaspora with families are reluctant to give up British schooling for their children. At the same time, they report missing the intensity and levels of work responsibility they may have had in South Africa. Given the high cost of living in the UK, salary differentials are not considered an incentive to stay (or not to return) and inclement weather and high housing costs in the UK are cited as incentives to return. Obtaining leave from UK medical institutions is difficult. The opportunities for both Diaspora and other UK health workers to go abroad are at the beginning of one’s career through internships of up to six months or at the end, when one is close to retirement. Going at other times is seen as detrimental to one’s career and advancement.

One UK South African Diaspora doctor observed that military doctors' training and expertise in the UK best prepare them for working internationally. He notes that programmes that have sent military doctors to underserved areas have generally been quite successful and that they are best prepared to deal with trauma cases. In general, he argued that those doctors who have specialised in surgery, trauma, and infectious diseases have the most to contribute to the South African context.

There are two or three regular South African newspapers published in London that are widely read amongst the Diaspora community. The South African High Commission with its base in London also has easy access to the majority of the Diaspora community living in the UK, hosts regular events for the Diaspora community, and provides a meeting venue for various South African associations (e.g. for South African nurses to meet or for Homecoming Revolution events).

3.3.3 US LEGAL/SOCIAL/POLITICAL CONTEXT

The South African Diaspora with American passports may also retain dual nationality but are taxed in both countries. Social security is also transferable. Socially, a move to the US (as well as to Canada, Australia, and New Zealand) generally requires a greater investment in financial resources and in obtaining one's professional certification and licensing than it does in the UK. In some cases, the move involves a secondary migration with an initial move to the UK to obtain professional licensing there and then another move to the US, Canada, New Zealand, or Australia.

The South African Diaspora in the US report the increased salary differentials and improved working conditions as important reasons for staying. As one UK Diaspora doctor facetiously observes about his American South African Diaspora counterparts, "Not one who has gone to the US will come back. Money has detribalised that group!"¹⁰

The US system has the most difficult and time-consuming registration and licensing procedures of the three countries. Visa requirements have also tightened along with the time required to obtain a work permit (Green Card). Once in a medical track or specialisation, it is difficult to step out for extended periods of time. Nevertheless, certain medical schools and particularly schools of public health support field internships and residencies (generally ranging from a few weeks to a year). The main issue for obtaining credit is ensuring adequate supervision and, for this reason, twinning and institutional exchanges are recommended. As noted earlier, the major constraint for a health worker spending time in South Africa (whether Diaspora or not) is repayment of his/her educational loans (loan forgiveness or delayed payment requirements are recommended for this reason) (Institute of Medicine 2005).

Politically, the Diaspora are easily assimilated into American society within a few years and their children are usually completely assimilated (Interviews with South African Diaspora in the US and UK 2007). Nevertheless, the Diaspora members interviewed indicated an ongoing interest in playing a supportive role in South Africa's development through the provision of scholarships, supplies, and short-term direct and virtual assistance. Medical Education for South African Blacks (MESAB), a Diaspora charitable organisation, has provided educational scholarships for a number of years.

Although the South African Embassy hosts various events and invites South Africans living in the US, its location in Washington, D.C. limits participation of many Diaspora (who live in other parts of the US). As in the Netherlands, the South African-American Chamber of Commerce publishes a regular newsletter, which is reportedly the most effective way of communicating with the South African Diaspora in the US. The largest South African Diaspora communities in the US are found in California, Oregon, Washington, D.C./Northern Virginia, New York, Massachusetts, Florida, and Colorado (Interviews in the US and the UK 2007).

The US has a long tradition of overseas voluntary service and internships and placements of six months to two years are not unusual (Interviews in the US 2007). Nevertheless, unless there is an explicit institutional affiliation and programme, those who work abroad have no guarantees for a post upon return. As in the UK, most doctors and nurses are likely to consider voluntary service abroad at the beginning or end of their careers – or to volunteer for short-term assignments during a holiday period. As in the Netherlands, many of the US health workers volunteer with religious groups and organisations.

3.4 Interventions to Address Resource Shortages

3.4.1 INTERVENTIONS IN SOUTH AFRICA

National Human Resources for Health Planning Framework:

In 2006, the South African DOH finalised this comprehensive policy framework, which aims to ensure the right HR mix in health to fulfil the country's health care delivery objectives. Specifically, the Framework seeks to address the issues of overall shortage of health personnel as well as the inequitable distribution between urban and rural areas and between the public and private sectors.¹¹ The Framework outlines 11 Guiding Principles with corresponding Strategic Objectives. Of particular concern to the issue of health worker migration is Principle 8, which states: "South Africa's contribution, in the short to medium term, to the global health market must be managed in such a way that it contributes to the skills development of health professionals." Corresponding to this Principle, the Framework outlines the

10. A noted medical anthropologist as well, he meant that they had lost a sense of having an ethnic South African identity.

11. See Department of Health, Republic of South Africa. 2006. A National Human Resources for Health Planning Framework.

“Optimisation of the bilateral agreements that South Africa enters into with various countries” as a Strategic Objective.

The Foreign Workforce Management Programme: The Foreign Workforce Management Programme Unit in the DOH oversees all aspects of the recruitment and employment of foreign health professionals in the South African health sector, including the regulation of recruitment, employment, migration and support towards residency status of foreign health professionals. The Unit manages an ever-increasing number of individual applications, as well as recruitment based on bilateral agreements South African has entered into with Cuba, Iran, and Tunisia.

Rural Scholarships: Initiated in 1998, scholarships for rural students have been offered in Mosvold Hospital in KwaZulu-Natal (Physicians for Human Rights 2006: 4-5). When the programme was initiated, the hospital had only two doctors serving 110,000 people and a catchments’ area of 2000 square kilometres. The “Friends of Mosvold Scholarship Scheme” (FOMSS) argued that local students had the potential to become health professionals and would be more likely to return to their districts to practise. Because of their material deprivation, most could not afford the high tuition costs. Once awarded a scholarship, students agree to work a year in the hospital for each year they are funded. In addition to funding for tuition and supplies, the Mosvold Scheme provides mentoring relationships. As of 2005, 14 students had successfully completed a degree programme and all had returned to that district as practising optometrists, physiotherapists, radiographers, and pharmacists. As of the same year, another 46 students enrolled in the programme. The initial success of this programme has inspired the Wits Initiative for Rural Health Education (WIRHE) at the University of Witwatersrand to replicate the programme with scholarships to students in North West and Limpopo provinces.

Compulsory Service: South Africa introduced a community service scheme for service to deprived areas for most health professionals to repay for their education and training. Some of the disadvantages to this scheme were that there was inadequate supervision of the newly trained personnel and that the scheme, at best, delayed migration by the year served (Dovlo and Martineau 2004: 39, also citing Reid 2001). Interviews in the UK and Netherlands (2006 and 2007) also suggest that some health care professionals migrated specifically to avoid compulsory service and being posted to areas where they felt “unsafe” or could not practise their proposed speciality and training. According to some Diaspora, the placements had little to do with matching skills and training to actual HR shortages and requirements (interviews in the UK and Netherlands 2007). Economists such as McClellan (personal communication 2007) argue that the South African Government should stop subsidising medical education and instead institute scholarships and loan programmes (especially targeted to those in rural areas).

Task-shifting: South Africa is considering measures to reduce the degree of specialisation required for nursing and medical training and decreasing its training for nurses from four to three years (Bach 2006: 17). The idea behind such proposals is that South African medical personnel skills would be less portable and less conducive to out-migration. Such proposals to “de-professionalise” the work force are strongly resisted by the professional organisations. Nevertheless, workforce strategies of substituting and delegating tasks that do not require medical training have been found to be a cost-effective means to increase access to HIV services (WHO 2006a). For example, many health care administrator posts could be held by public and community health workers, which would also provide more employment at lower costs in professions where there are fewer openings. According to WHO (Ibid), task-shifting requires new programmes of training and certification to guarantee quality and standards of care.

Private-public Sector Partnerships: Private-public sector partnerships to increase health care human resource are underway in South Africa. One publicised example is that of BroadReach Healthcare, an American NGO that utilises private-sector providers to offer services to poor and uninsured clients. By networking with private treatment programmes, such as Aid for AIDS, a South African-based organisation, BroadReach encourages private physicians who have the capacity to take on public patients, including uninsured and those in remote areas who would not otherwise have access to any care. (So far, a network of over 4500 doctors exists across the country.) The programme uses **telemedicine** to provide specialist support to the general practitioners in the field as well as monitor each individual patient’s clinical outcomes. All treatment decisions are vetted by a specialist at the Aid for AIDS remote-decision support centre in Cape Town.

The programme is intended to provide high-quality treatment services to remote communities, eliminating the need for sick patients to travel long distances to receive care, in this way making it easier for drug treatment compliance and adherence. Funds for the drugs, diagnostics and the medical care currently come from PEPFAR.

3.4.2 INTERVENTIONS IN OTHER COUNTRIES

Compulsory Service versus Incentive Payments: A World Bank study of doctors’ revealed and stated preferences to relocate in remote areas in Indonesia provides interesting insights and parallels to the South Africa situation (Chomitz 1997). As South Africa did, Indonesia initially mandated compulsory service to encourage postings in remote rural areas. However, as the study found, compulsory service has a gender bias for women who may not be able to serve in remote areas and was inherently inequitable since the wealthier could afford to buy their way out. The study also found that such compulsory service had

the unintended effect of encouraging doctors to abandon their practices and/or to leave the country. An analysis of doctors' actual preferences demonstrated that modest incentive payments were sufficient to encourage doctors to relocate to remote areas. The study further showed that if the supply was still short, specialist training could be offered. The incentive of **access to specialised training** eventually turned out to be expensive and proved to attract people with the wrong skills and attitudes. To retain doctors in remote rural areas, the Indonesian study found that civil service employment was not necessary but indefinite contract renewals were a motivating factor. The use of public health graduates versus physicians as managers of rural clinics was also recommended since the public health graduates had fewer employment prospects and were more willing to relocate to these areas.

Improving Salaries, Benefits, and Working Conditions:

According to Physicians for Human Rights, the Government of Haiti has also increased its retention of doctors by providing reasonable salaries, Internet, career building opportunities, and well-resourced facilities. In Ghana, a similar strategy of increasing doctors' salary levels to make them competitive on the international market is underway. Preliminary results, however, suggest that this kind of incentive is increasing retention of doctors but strapping the General Health Service's budget so that there is now insufficient funding to equip and supply the public health sector. As one World Bank Ghanaian health advisor observed: "We are now paying doctors more to show up and do nothing" (Long and Mensah 2007). In addition, the increased disparity in salary levels has created resentment and strikes amongst the nursing profession.

In Malawi, the UK Department for International Development (DfID) has provided GBP 55 million over six years to fund an emergency human resource programme (UK House of Lords 2007). The programme is helping to build the health service and be an incentive package so that health care professionals will want to train and remain there. A recent evaluation provides some evidence that fewer staff are leaving the service and DfID is currently planning to extend the programme to more remote areas. Although it is not clear that such a programme can be sustained without external funding, Malawi provides a model for government-to-government compensation.

Community Health Workers: Cited by Physicians for Human Rights (2006) as a successful intervention, Haiti is training community members to provide TB and antiretroviral treatment. In Ghana, new programmes have been organised to train locally based community health workers to serve as lab technicians, conduct community outreach, and provide case management and counselling. Likewise, the Government of Kenya is training community dental assistants and Uganda is providing training and field internships in community health. These kinds of

interventions are proving to be a way to fill critical gaps at lower cost. Such health care workers also do not have portable degrees and, therefore, are less likely to immigrate. At the same time, these kinds of programmes also provide needed employment.

Health Centres of Excellence: Iran has organised culturally relevant health houses, which are backed up by higher-level health facilities (Physicians for Human Rights 2006). A Wellness Centre of Excellence for Health Workers in Swaziland is offered by the Swaziland Nurses Association with support from the Danish Nurses Association and International Council of Nurses (Ibid).

Teleconferencing Support: Several UK Ghanaian doctors have been using Internet, video and teleconferencing to provide on-going medical advice and support to rural health centres. Such support, coupled with intermittent short-term returns and exchanges under IOM's MIDA/Ghana programme, has allowed for specialised services to be extended to rural areas. According to the participants, however, both direct and virtual returns and exchanges are required to allow for effective communication at a distance. The Center for Disease Control (CDC) in Atlanta offers a series of web-based advisory information and diagnostic services, which many more health care workers could utilise if they had the requisite Internet facilities, access to assured power supplies, and training.

Mobile Units: Several countries support mobile health units to increase access to health services in rural areas. This mode has also been used successfully with highly mobile populations in refugee and migrant camps. HIV and AIDS social marketing campaigns (and, in some cases, services) are also offered in some airports, and on railways and ships.

International and Diaspora Recruitment: The UK's Lord Crisp Report and the US Institute of Medicine, "Healers' Abroad", both recommend encouraging the return of Diaspora professionals and international recruitment to facilitate temporary and short-term migration to fill critical health care shortages. IOM's Return of Qualified African Nationals (RQAN) and the Migration for Development in Africa (MIDA) are cited as models for utilising the skills and expertise of Diaspora personnel to address critical skill shortages (Dovlo and Martineau 2004: 40). A key advantage noted is that the Diaspora and migrant doctors share a common culture and language. A recent evaluation of the MIDA/Ghana pilot project also suggests that such support for even short-term temporary returns has encouraged the Diaspora to invest their time and resources through official channels and to register with the health professional associations. In terms of international recruitment, the UK's VSO, the US CDC, and US Crisis Corps (in the Peace Corps) all have extensive experience and large-scale models for recruitment and placement of volunteer and other expertise in the public sector. Major incentives for recruiting such expertise are deferred loan packages and well-targeted placements (where needs match expertise).

4. IDENTIFICATION AND MAPPING OF RELEVANT INSTITUTIONS AND ASSOCIATIONS IN THE NETHERLANDS, THE UK, AND THE US

This section identifies and maps the relevant institutions and associations in the Netherlands, the UK, and the US. The relevant institutions and associations are categorised, as follows: (1) ministries and departments, including development organisations; (2) academic/professional partnerships and exchanges; (3) private initiatives – foundations, NGOs, and for-profit institutions. The methods used to identify and map the relevant exchanges and relationships were: (1) the advice of the First Secretary/ Medical Officer of the Embassy of South Africa in Washington, D.C., the First Secretary of the South African High Commission in London, and the First Secretary of the South African Embassy in The Hague; (2) the advice of the professional societies in each of the three countries; (3) recommendations of other groups and organisations working in South Africa; (4) recommendations of South African health care and other Diaspora in each country; and (5) the profiles of relevant institutional exchanges provided in two major government reports (Institute of Medicine 2005; Lord Crisp 2007).

Since many of the exchanges between South Africa and each of the three countries are informal, individual initiatives, it is impossible to map all the possible exchanges that have occurred or are occurring. Many small religious groups in particular have missions that recruit and place health care workers. Students from several different schools of medicine and/or public health also organise projects and internships in South Africa, particularly HIV and AIDS and maternal and child health projects. In addition, various development projects organise exchanges and placements for periods of time to meet specific project needs.

The difficulties in mapping all the disparate and diffuse initiatives suggest the importance of developing a central clearing house in South Africa to encourage overseas and foreign health care professionals and organisations (both public and private initiatives) to register their activities so as to prioritise placements to areas of greatest need and to share information and best practices. Such registration and information sharing could begin at the embassy or high commission level since the First Secretaries in each place were very knowledgeable, dedicated, and more than willing to assist, during interviews and mapping visits conducted in 2006 and 2007. South African Diaspora groups could assist in developing registries of services and expertise as well as announcing critical shortages and openings.

The summary that follows is based on interviews, websites, and project documents of various organisations. Providing only brief synopses of some of their key activities, this summary does not claim to capture all the work being undertaken by any one

particular organisation or all the work that is currently being done to address health worker HR development in South Africa.

4.1 The Netherlands Health Care Exchanges and Placements

4.1.1 MINISTRIES AND DEPARTMENTS

In the Netherlands, the ministries of foreign affairs, technical cooperation, and health are all involved in medical exchanges and placements. However, as a key advisor for Technical Cooperation observes, only HIV and AIDS is currently a priority in the Netherlands' assistance to South Africa. However, such support does not include addressing HR shortages to support service delivery. From the perspective of this ministry, health care shortages are more acute in several other priority-assistance countries and it would consider engaging in this issue only in terms of the SADC region as a whole.

On the basis of its "Policy Memorandum on Development and Migration", the Ministry of Foreign Affairs (MFA) currently promotes the MIDA/Ghana programme to encourage circular and short-term migration of health care workers from the Netherlands and the UK to Ghana (Government of the Netherlands, Ministry of Foreign Affairs 2004). The MFA is currently assessing the extent to which the MIDA pilot could be broadened to address EU-level migration and development objectives.

4.1.2 ACADEMIC/PROFESSIONAL PARTNERSHIPS AND EXCHANGES

Key institutions are **schools of public health**, professional associations, and the speciality of tropical medicine and infectious diseases. Efforts to date tend to be small scale and private, and reflect personal ties and relationships. In the Netherlands, Sierra Leone and Ghana are seen as high priorities for placements.

Nevertheless, KIT, the Royal Tropical Institute in the Netherlands, has a strategic partnership in Namibia with "Health Development for Africa" (Anthony Kinghorn. <http://www.hda.co.za>) and they work together on HIV and AIDS projects. Dr. Prisca Zwanikken, MD MScCH, Area Leader Education, KIT Development Policy and Practice, indicated KIT's interest in and willingness to develop twinning projects and collaborative exchanges with South African institutions to create "Centres of Excellence" in rural and underserved areas. She noted that there is EU funding (see <http://erasmusmundus.troped.org>) and that South Africa could submit a specific request to develop such an institutional relationship.

Through the SHIELD project, KIT is also undertaking a critical analysis of the existing health system in three African countries

(Ghana, Tanzania and South Africa) to identify their major equity challenges. This project also includes health care financing and cost/benefit incidence studies. This information will form the basis for considering alternative approaches to health insurance within these countries, as a mechanism for addressing health system equity challenges and, in turn, contributing to achieving the Millennium Development Goals. Key themes (issues/emphases) will be mandatory insurance, insurance mechanisms for covering those outside formal employment, and maternal and child health. The extensive experience of mandatory health insurance within Europe will contribute to understanding the potential for such insurance to be implemented successfully and sustained in a way that contributes to overall health system equity. The combination of economic and policy analysis approaches enables analysis both of the technical options for policy design and the political acceptability of these options. The project involves policy makers in key aspects of the research and the findings will be made available to them at an early stage to maximise the potential for the research to inform health insurance policy decisions. Finally, the innovative methodological tools developed for certain aspects of the research will be documented in a toolkit to ensure accessibility for researchers from other contexts wishing to undertake similar analyses.

4.1.3 PRIVATE INITIATIVES – FOUNDATIONS, NGOS, AND FOR-PROFIT INSTITUTIONS

PSO, a Dutch NGO located in The Hague, sets recommended local salary rates and compensation packages for Dutch international exchange programmes, which are designed to benefit countries with shortages. PSO provides standard tables for different professions according to experience and age. For example, a doctor of 50 years might receive a local salary equivalent to 3000 euros/month, whereas a younger doctor might receive 1500 euros/month. PSO (in contrast to VSO which comprises solely volunteers) tries to determine a fair local cost structure and compensation package. PSO receives fees for its NGO services, which include establishing rate tables and organising transport and various insurance schemes. For the small NGOs, their rates may be considered too costly (Interviews in the Netherlands 2007).

Dr. Fred Nederlof of Worldwide Surgery has foundation and government funding to develop a database of all doctors that are active in developing countries and/or wish to be posted there. Within the coming year, Worldwide Surgery expects to have an operational website on which countries and employers may list available openings and that will provide profiles of doctors interested in working abroad. The profiles will include doctors' specialities, how long they are willing to work abroad, and where they desire to work.

Dr. Nederlof works with the Dutch Society of Medical Specialists to design this site. He notes that they do not want to compete

in any way with NGOs already doing such placements but that they have observed that many doctors individually are interested in such experiences and in exploring their options. The purpose of the website is to improve the overall efficiency of international placements for Dutch doctors. Various departments and ministries of health will be able to post openings. Once the database is established, Dr. Nederlof expects that nurses will be welcomed as well. On the basis of prior research, they expect to register on the database between 1500 and 2500 doctors from the Netherlands alone who have experience and interest in working abroad. Once the database is working, it might be expanded to include other EU countries.

Currently, Worldwide Surgery works in Sierra Leone and Dr. Nederlof sends there ten teams of two doctors and two nurses (a total of 40 people annually). For its second medical team to Sierra Leone, Worldwide Surgery built a guest house with Internet and Skype/webcam (organised through a collective contract with a satellite provider). Such services provided motivation for both the Dutch and Diaspora doctors to return often and more frequently. Worldwide Surgery also provides online medical specialists in the Netherlands for special cases that local doctors are unable to treat.

The **Stellenbosch Foundation** in the Netherlands will continue to provide support to improve the infrastructure and the quality of the graduates of the University of Stellenbosch's Medical School through short-term returns of Diaspora doctors, who conduct specialised training and provide small grants, equipment, and scholarships for medical students from rural areas.

None of the major Dutch development NGOs send doctors to South Africa, including VSO and Médecins sans Frontières (Doctors without Borders), which send doctors and nurses elsewhere (Interview with Clara Blaauw, Coordinator of **Consilium on Education in Tropical Medicine**, and Dutch Society for Tropical Medicine, 2007). **CordAID** receives funding from the Ministry of Development Cooperation for its work in HIV and AIDS in South Africa and is involved in health care worker placements in other countries.

All Dutch doctors and nurses working in South Africa are currently on local contracts. They report encountering enormous difficulties in getting even a local stipend and in obtaining residency visas and work permits there (Interviews in the Netherlands 2007). These obstacles have deterred many young residents who would be willing to work for two to three years in South Africa, even at local salary rates. Currently, most are sent by small foundations and religious groups and these visits may be better organised. Compared to five years ago, there is reportedly an increase in the number of the doctors and nurses going to South Africa because salaries are quite good and people are able to bring their families. Most are working in the private sector, offering specific specialities, and/or for religious missions.

4.2 UK Health Care Exchanges and Placements

4.2.1 MINISTRIES AND DEPARTMENTS

Within the UK Government, the DOH, the Department for International Development, the Home Office and the Foreign and Commonwealth Office were all involved in drawing up the MOU with the South African Government. In the UK, South Africa is seen as a priority country because of the ties, the continuing outflow of South African professionals to the UK, and the similarities of the two countries' health care systems and training. On the other hand, the **DOH** is concerned that exchanges will facilitate further out-migration and result in renewed criticism of the UK as facilitating a "brain drain". The Home Office does not consider South Africa a priority country for its assisted voluntary return programmes or deportations.

4.2.2 ACADEMIC/PROFESSIONAL PARTNERSHIPS AND EXCHANGES

There are many individual internships and exchanges through UK medical and public health schools and South Africa. What follows are some specific recent programme initiatives and individuals, who were recommended by the South African High Commission.

Dr. Cecil Helman, Chair of the Department of Primary Care and Population Sciences, **Royal Free and University College Medical School**, is a South African who sought political asylum in the UK during apartheid. From 1997 to 2004, he organised a seven-year exchange programme of research and teaching between his department and the Department of Family Medicine, University of Transkei, Eastern Cape. Helman (Interview in the UK 2007) argued that this programme, funded by the Higher Education Link programme, was "considered one of the most successful". As a medical anthropologist as well, he organised a collaborative research project to study "perceptions of childhood immunisations in rural Transkei". Between 1997 and 2000, the programme involved a consortium of medical institutions including the University of Cape Town, University of Liverpool, University College London, and the University of Transkei. On the basis of his experience with the exchange programme, Dr. Helman argues strongly that linguistic and cultural differences need to be taken fully into account in sending foreign health care personnel and in developing institutional twinning relationships and exchanges. Nevertheless, he suggests that the various institutions benefited positively from the exchange. A "Distance Learning Masters" in Primary Care with University College London and the University of Transkei has been developed as one of the outcomes of these exchanges.

King's College provides training for a limited number of South African nurses. The college found that some nurses did not want to return and a major drawback was that they were discouraged

about the possibility of transferring their new skills and expertise back to their South African posts.

The **University Hospital of Radcliffe College, Oxford University** offers short-term internships and placements for its medical residents in the Western Cape. These doctors assist in providing maternal and child health (MCH) services and HIV and AIDS services. Cited in the Lord Crisp Report (Crisp 2007: 73) is Richard Jones, an experienced health service manager from Oxford, who spent a year on management capacity building, strategic planning, and the development of policies and procedures in the Northern Cape Department of Health and Kimberley Hospital Complex. Jones's secondment resulted from a twinning partnership between the Kimberley Hospital Complex and Oxford Radcliffe Hospitals. Initially, the twinning began with the exchange visits by senior management of each hospital complex and, in 2002/3, progressed to clinical exchanges. Some 28 nurses from the Northern Cape spent six months working in the Oxford Radcliffe Hospitals and three nurses from Oxford spent a month working in Kimberley.

Professor Sir David Hall and Dr. Susan Hall in "quasi-retirement" are working for a second time in South Africa (Ibid: 73). Professor Hall is a past president of the Royal College of Paediatrics and Child Health and Dr. Susan Hall is a consultant in infectious disease epidemiology (Ibid). Thirty years ago, they spent three years working at Chris Hani Baragwanath Hospital in Soweto before returning to work in the NHS (Ibid).

Other UK University medical programmes that traditionally have overseas research, internship and fellowship activities are the Ross Institute, Liverpool School of Tropical Medicine (which has been working in the DRC), the Fistula Network set up by the International Federation of National Societies of Obstetrics and Gynaecology (in London and which has been working in Tanzania), and Mercy Ships, a global charity that has engaged many UK doctors (Ibid: 74).

4.2.3 PRIVATE INITIATIVES – FOUNDATIONS, NGOS, AND FOR-PROFIT INSTITUTIONS

The **King's Fund**, a British charitable foundation, addresses health inequities. Originally started over a century ago to support hospital care for the London poor, today the King's Fund is involved in "developing ideas, services, and people" for London and beyond (King's Fund 2006: 1; King's Fund 2005/2006). Its President is HRH the Prince of Wales.

In South Africa, the King's Fund has initiated a number of leadership training programmes. The King's Fund, for example, prepares NHS/DOH executives to work in South Africa as part of the official government exchange programme. Martin Fisher (a South African) at the King's Fund organises the cultural orientation

and preparation for the NHS/DOH teams, focusing on leadership and management training. On the basis of his experiences, Fisher argues that the HR issues will not be addressed by slotting yet another 1000 more nurses into a system that is badly organised. During his interview in 2007, he recommended that external support and training be initiated at management level. In terms of exchanges, he recommends sending groups of senior NHS administrators (who were losing their posts and being declared redundant in the current round of NHS cost-cutting) to provide management advice and support to groups of South African public sector institutions. He recommends outside technical assistance be organised with groups of institutions so as not to displace existing personnel and their expertise. According to Fisher, since many of the senior NHS administrators are receiving excellent compensation packages, many might be willing to volunteer their time and/or be paid at local rates to provide such advice and support.

EQUINET, through the University of Namibia and Health Systems Trust and in cooperation with the Regional Health Secretariat in East and Southern Africa (ESA), is implementing in ESA research, capacity building and country programmes to monitor, evaluate and manage incentives for the retention of health workers, particularly non-financial incentives, and to review costs and benefits of health worker migration. This initiative is funded by DFID. Two studies are underway: (1) non-financial incentives for retention of health workers in ESA; and (2) the distribution of costs and benefits of health worker migration within and beyond ESA.

Homecoming Revolution provides information and advice to returning South African Diaspora. With funding from the South African Government and numerous private South African and international businesses working in South Africa, Homecoming Revolution encourages the return of health care workers to fill both private and public sector openings. For all potential employers and candidates, Homecoming Revolution provides information on openings and provides “impartial advice” on regularising one’s return status, obtaining employment, and socio-cultural re-entry (e.g. organising regular meetings for different returnee groups) (Interview in South Africa 2006; Homecoming Revolution promotional material). Homecoming Revolution has focused most of its recruitment efforts to date with the over one million Diaspora in the UK (with over 90% in London alone) but is also expanding to Ireland, the US, Canada, New Zealand, and Australia (Interviews in South Africa 2006).

With Netcare, Homecoming Revolution organises Diaspora nurses’ returns from the UK, including: specific placement in a Netcare facility; payment for flights home; assistance with the nurses’ SANC registration, training and orientation programmes; and assistance with accommodation. As of January 2007, over 60 South African Diaspora nurses in the UK had returned through this programme.

With its headquarters in South Africa, the **Rural Health Initiatives (RHI)**, organised by and in collaboration with the Rural Doctors Association of South Africa (RUDASA), recruits and places both Diaspora and other health professionals in the UK to work in rural hospitals in South Africa for at least 12 months. The support is aimed specifically at rural areas where there is a major shortage of doctors and other health professionals. RHI has placed doctors in hospitals in KwaZulu-Natal, the Eastern Cape, North West, Free State, Limpopo and Western Cape. Organised in 2004, RHI began recruiting doctors and nurses two years ago and has recruited and placed 125 doctors to date (and has another 125 potentially in the pipeline). RHI has a part-time organiser in the UK and an HR specialist in South Africa who work on a regular basis with the South African High Commission and the government to facilitate registration with the Health Professions Council of South Africa (for those who have qualified outside of South Africa) and work permit/visa requirements. According to Tracy Hudson and Martin Schneider, RHI organisers, key to their success is having a well-organised orientation and on-going contact and support for the participants.

RHI organisers observe that registering doctors is not difficult but in the case of nurses the current requirement that the nurses sit a Moral Values test prior to being considered for registration is a strong deterrent to recruiting nurses from outside South Africa. Most foreign nurses cannot afford either the time or funding for two trips to South Africa just to be registered. For this reason, to date, the few nurses recruited have been mostly wives of doctors in the programme. RHI receives funding from the Canadian International Development Agency (CIDA); Discovery Health; South African medical aids and over 20 private companies.

The **Tropical Health and Education Trust (THET)**, a charitable organisation with funding from many diverse public and private donors, is promoting twinning relationships and exchanges in African countries that are experiencing the most acute health shortages (e.g. Malawi, Ghana, and Ethiopia). THET does not work in South Africa but provides relevant models and experiences in addressing HR shortages through twinning projects and exchanges. In the SADC region, THET has various health training and resource projects in Malawi, Mozambique, Swaziland, Zambia, and Zimbabwe.

4.3 US Health Care Exchanges and Placements

4.3.1 MINISTRIES AND DEPARTMENTS

In May 2003, the US Congress approved, and President Bush signed into law, the “United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003” (PL108-25). This legislation became the **President’s Emergency Plan for AIDS**

Relief (PEPFAR), a five-year \$US 15 billion global initiative to combat HIV and AIDS (PEPFAR 2007). Congress mandated that 55% of the money be spent on the treatment of individuals with HIV and AIDS (and in fiscal years 2006-2008, 75% was to be spent on the purchase and distribution of antiretroviral therapy and another 15% on palliative care). The **US Global AIDS Coordinator** based in the US Department of State is responsible for coordinating all HIV and AIDS activities.

The National Institutes of Health (NIH), CDC, the Office of the US Global AIDS Coordinator, the US Agency for International Development (USAID) and its contractors, and Peace Corps/Crisis Corps all have various training interventions and other medical programmes in South Africa. Since South Africa is considered one of the priority 15 PEPFAR countries, the majority of USG assistance and support to South Africa primarily addresses HIV and AIDS, tuberculosis, and malaria treatment and initiatives.

The various programmes are coordinated through PEPFAR and demands for specific services are expected to be generated within the designated country through the PEPFAR Coordinator in the US Embassy of that country. Nevertheless, government officials from several different departments and agencies observe that the Global AIDS Coordinator/PEPFAR structure adds a layer of complexity that has slowed down the USG's capacity to respond quickly to a specific request. Within this new centralised coordination, support for a specific HR initiative generally takes a year and should commence during April-June (the planning phase) through specific requests from the South African Government through the local coordinator's office in the US Embassy.

Within USAID, there are also centralised projects, funded and organised through American contractors that address HR requirements. The main project addressing HR is USAID's **Capacity Project**, whose purpose is to "strengthen the HR needed to implement quality health programs" (USAID 2006: 46). IntraHealth International is the prime contractor for the Capacity Project and its implementing partners include: Emerging Markets Group Ltd; Interchurch Medical Assistance; JHPIEGO (an international health organisation affiliated with Johns Hopkins University); Liverpool Associates in Tropical Health; Management Sciences for Health; the Program for Appropriate Technology in Health (PATH); the Statistical Analysis System (SAS) Institute; and the Training Resources Group (TRG).¹²

Other **USAID centrally funded projects** that address HR issues include: (1) the US Peace Corps' programmes to promote and expand community-based prevention in HIV and AIDS; (2) Health Systems (20/20) – under review; (3) Partners for Health Reform plus (PHRplus) – to be awarded; (4) Quality Assurance/Workforce

Development (QA/WD) – University Research Company; (5) Infectious Disease Results Package: Centers for Disease Control – to access technical expertise from CDC; (6) TB Country Support Contract – technical assistance and advisory services through PATH; and (7) ACCESS project – maternal and child health technical assistance and interventions – led by JHPIEGO.

PEPFAR internships are being organised through the **Placement Project**, a project based in South Africa that will select and match Masters in Public Health (MPH) students to South African AIDS service organisations. According to the organisers: "Since the PEPFAR Internship Program (PIP) is so new, we cannot yet accurately gauge its long-term impact". The intent is that the organisations where the MPH students are placed will offer them longer-term contracts after the initial internship period. However, this may change. "We are currently exploring options with AIHA [American International Health Alliance] to recruit volunteer systems managers for new ARV clinics; we are always open to expand the scope of our recruitment" (Johnson email 18/10/06).

PEPFAR also has strict guidelines for the internship project, which is limited to placing only South African interns. Whilst there are a few exceptions for international students, preference is given to South African students. However, the Placement Project expects that the PIP will publicise its available services and expand the scope of its own work. So far, responses from four large medical programmes in South Africa (including the universities of Witwatersrand, Pretoria, and Cape Town) have been encouraging.

4.3.2 ACADEMIC/PROFESSIONAL PARTNERSHIPS AND EXCHANGES

There are innumerable American academic and professional initiatives that support exchanges, internships, and placements in South Africa at the individual level. The partnerships and exchanges profiled here were recommended by the South African Embassy in Washington, D.C. and Dr. Fitzhugh Mullan (who has worked extensively in South Africa and chaired the Committee on the Options for Overseas Placement of US Health Professionals). On the basis of the author's own experience in organising international health exchanges with schools of public health, she has also included schools that have an international department or focus.

Several **US schools of public health** offer and/or have had international internships, exchanges, and placements in South Africa. Tulane School of Public Health (New Orleans) is particularly known for its focus on tropical public health and has a joint masters programme in public health with the US Peace Corps. Other schools of public health that have international internships and exchanges include: Johns Hopkins (Baltimore); Harvard

12. JHPIEGO, SAS and PATH are all known today by their acronyms.

(Cambridge); Columbia; University of California/Los Angeles ; University of North Carolina; Rollins School of Public Health; Emory University (Atlanta); and George Washington University (Washington, D.C.). In the US schools of public health train doctors, nurses, and other health care specialists. Along with medical departments in infectious and tropical diseases, these schools have programmes and exchanges that are the most relevant to international work and to twinning relationships. Nevertheless, there are also a few nursing programmes with specialities in international nursing (e.g. Georgetown University and the Lillian Carter Center for International Nursing, Emory University).

Yale University has placed around the world some 150 medical residents from tropical medicine and other specialities. Dr. Michele Barry, Professor of Tropical Medicine and Infectious Diseases, the Director and Organiser of the programme, has a special interest in and personal experience of working in South Africa and Zimbabwe. Dr. Barry was also a member of the Institute of Medicine panel that called for a “medical Peace Corps” for underserved areas and advocated exchanges and the creation of rural “centres of excellence” to provide incentives for local doctors.

The **Inter-Diaspora Dialogue Initiative (IDDI)** is organised by the George Washington University Center for Health and Human Security in collaboration with the Diasporas, Policy and Development Program (George Washington University, Elliot School of International Affairs) and the GWU School of Public Health, Department of Health Policy (2006: 1). The IDDI's purposes are: (1) to improve the capacity of US African immigrant professionals and organisations to contribute to the development of their origin countries by sharing best practices, lessons learned, and building Diaspora networks in health and education; and (2) to encourage policy makers to utilise Diaspora expertise in policies and programmes. The IDDI plans to organise a workshop series, develop a networking website, design curriculum and training models, and conduct research.

4.3.3 PRIVATE INITIATIVES – FOUNDATIONS, NGOS, AND FOR-PROFIT INSTITUTIONS

AcademyHealth, a non-partisan, scholarly society for health services researchers, policy analysts, and practitioners, is examining international nurse recruitment that has emerged in response to US nurse shortages. The project seeks to reduce the harm and increase the benefits of international nurse recruitment for source countries and to ensure that the rights of migrants are considered throughout the recruitment process. AcademyHealth works with the US companies and hospitals that are currently recruiting nurses and other professionals from abroad to document current practices and to propose strategies for reducing the harm and maximising the benefits that their actions may bring about at both the health system level in source countries or at the level of individuals interested in migration.

Since September 2006 AcademyHealth has been studying the emergence, current practices, and future prospects of the nurse-recruitment industry and will carry on its research until 2008. It plans to facilitate a consensus-building process with recruiters, hospitals and foreign-trained nurses that will lead to the development of a draft “standards of practice”. The project will end with a joint proposal by these organisations to disseminate and promote its endorsement. The initiative is funded by the MacArthur Foundation.

Africare, a US NGO, is developing a programme to address health care resources in South Africa's Eastern Cape but could not be reached for comment. Two current Africare programmes seem relevant to addressing HR issues for health. The first is “Africans helping Africans”, Africare's HIV and AIDS Service Corps, which encourages Africans to volunteer in their own communities to meet with locally identified needs. Building on existing programmes, Africare seeks to develop indigenous volunteers, supported by very modest stipends, who are willing and able to provide HIV and AIDS support. In June 2002, Africare launched the Service Corps in ten countries: Burkina Faso, Cote d'Ivoire, Ethiopia, Ghana, Guinea, Mali, Namibia, Rwanda, Uganda, and Zambia and has supported over 70 volunteers.

The second Africare programme, the **Soweto Digital Village**, funded by the Bill and Melinda Gates Foundation, equips more than 500 youth with the computer skills to compete in the job market and/or to link to universities on line. Trained by Africare, volunteers from the community tutor at the digital villages. The Soweto Digital Village, with 35 multimedia workstations, has more than 1000 registered members. The centre assists an average of 200 computer users each day.

Established in 2000 by the Merck Company and Foundation, the Bill and Melinda Gates Foundation, and the Government of Botswana, the **African Comprehensive HIV and AIDS Partnerships (ACHAP)** support Botswana's response to the HIV and AIDS epidemic through a comprehensive approach to prevention, care, treatment and support. The Merck Company Foundation and the Bill and Melinda Gates Foundation each are contributing \$US 50 million to the initiative. In addition, Merck is donating its antiretroviral medicines to Botswana's national antiretroviral therapy programme – known as Masa (or “new dawn”) through 2009 (the project's duration). The project has supported the construction of 32 new treatment centres and trained over 1100 health care workers (International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) 2007).

Baylor College of Medicine in Texas offers international exchanges and medical internships with Rhodes University, Grahamstown, in the Eastern Cape. Students from each university must register first and be accepted into the counterpart institution for the exchange period.

As part of a five-year Bristol-Myers Squibb initiative entitled “Secure the Future: Care and Support for Women and Children with HIV/AIDS,” the Baylor International Paediatric AIDS Initiative is coordinating a nurse education and physician exchange programme between Botswana, Lesotho, Namibia, South Africa, and Swaziland.

The Baylor Physician Exchange Program involves a two-month education and training programme in the US for Southern African physicians with a special interest in AIDS and responsibility for the care of HIV-infected individuals. This programme, conducted at Baylor College of Medicine in Houston, Texas, and affiliated institutions, includes a formal series of lectures and case discussions pertaining to AIDS, as well as participation in AIDS outpatient and inpatient clinical activities. A programme focus is HIV prevention and treatment amongst women and children (Baylor International Pediatric AIDS Initiative 2007).

BroadReach Healthcare, a US NGO, utilises South African private sector networks to provide services to poor and uninsured clients from the general public. By networking with private

treatment programmes, such as Aid for AIDS, a South African-based organisation, BroadReach encourages private physicians (so far a network of over 4500 doctors across the country) who have the capacity to take on public patients, including the uninsured and those in remote areas who would not otherwise have access to any care.

Center for Global Development, a Washington, D.C. think tank, provides policy research to reduce global poverty and inequality. Michael Clemens, Gunilla Pettersson, and Mead Over at the Center are all directly involved in providing evidence-based statistical research on health professional emigration from Africa, based on which they have developed a database. Their work is funded in part by the MacArthur and Hewlett Foundations.

South African Partners (SA Partners) and the Commonwealth of Massachusetts (Mass Med) with the Provincial Government of the Eastern Cape are playing a critical role in the development of the Masihlangani “Let Us Come Together” Network. Findings and Recommendations for Policies and Programmes

5. FINDINGS AND RECOMMENDATIONS FOR POLICIES AND PROGRAMMES

The following key findings and recommendations are organised according to the different kinds of health care worker migration flows that exist to and from South Africa. The findings and recommendations relate to: (1) retaining health care workers (and decreasing the current emigration from the region); (2) promoting new internal migration flows of health care workers to address critical health care shortages in rural and other underserved areas; (3) attracting South African Diaspora health care workers back to South Africa (and encouraging immigration); and (4) attracting other foreign health care workers to South Africa. The principal findings are presented followed by the recommendations pertaining to each kind of movement. The recommendations are categorised according to their policy or programmatic relevance.

5.1 Retaining Health Care Workers in the SADC Region

5.1.1 FINDING – INCENTIVES TO REMAIN

Although South Africa’s health care HR shortages do not rank in the highest category of need, the country’s shortages and relatively attractive salaries draw doctors, nurses, and other workers away from other countries throughout Africa. Despite an explicit South African national policy to discourage hiring doctors from other resource-

strapped countries, such policies do not take into account doctors’ and nurses’ inability to practise in certain situations of conflict or where needed supplies and materials are scarce. In addition, such policies are difficult to enforce with South Africa’s growing and diverse private sector. Policies to restrict migration of certain key personnel have only limited effectiveness and often lead to under-employment and brain wastage. Creating conditions that encourage health workers to stay is the most sustainable approach.

5.1.2 POLICY RECOMMENDATION – DOMESTIC RETENTION

South Africa will drain fewer doctors from neighbouring countries if it strategically identifies and addresses its own HR health care worker shortages. Other SADC countries with shortages will benefit if South Africa implements specific strategies and programmes to retain its own stocks of health care workers.

5.1.3 POLICY RECOMMENDATION – AVOIDING WASTAGE

The current policy, initially proposed by RUDASA, to employ doctors primarily from countries that will not be materially affected by the losses of health care personnel should be maintained. Nevertheless, given current shortages worldwide, some consideration should be given to whether doctors and nurses are able to practise and are practising in their countries of origin.

5.1.4 PROGRAMME RECOMMENDATION – COMMON REGIONAL STRATEGIES

Regional HR strategies and lessons should be shared through a SADC forum. A SADC-wide strategy of improving HR flows and the retention of doctors should be devised and adopted. The region as a whole should discuss and devise common standards, practices, and retention strategies related to workplace conditions, workplace safety, appropriate salary remuneration, training, etc.

5.1.5 PROGRAMME RECOMMENDATION – SHARING SUCCESSFUL MODELS REGIONALLY

Successful donor-funded models and retention strategies (e.g. the Malawi experience) should be generalised across the SADC region. Successful strategies to attract and retain personnel in one country may lead to losses of health personnel in another.

5.2 Promoting New Internal Migration Flows of Health Care Workers

5.2.1 FINDING – RETAINING PUBLIC EMPLOYEES AND INCREASING PRIVATE RESPONSIBILITY

Efforts to address the current HR shortages in health care must take into account internal flows and factors that drive health workers from rural to urban sectors, from public to private institutions, and from health care to non-health care professions. These factors reflect poor working conditions, fear of crime, inadequate remuneration, lack of opportunities for advancement, occupational hazards, burn out, etc. Reversing flows to the private sector, attracting health workers to work in disadvantaged areas, and encouraging health care workers who have stepped out to re-enter the profession require a mix of incentives and commitment to improving the overall management and performance of the health care system. They also require attracting into the profession those who are willing and dedicated to work in such areas. Finally, they may require that the private sector bear greater responsibility for addressing the health care needs of all citizens.

5.2.2 POLICY RECOMMENDATION – MOBILITY OF LABOUR

The mobility of labour is as much a domestic as an international phenomenon. Retention strategies must focus on providing the proper mix of incentives and wise management of all available resources rather than restrictive policies to curb migration or labour flows to the private sector. Providing accurate and up-to-date information about labour markets is critical to improving health workers' own decision making and deployment. Political considerations in managing health care systems tend to lead to wastage and "boom-bust" cycles in efforts to curb costs at a given time.

5.2.3 POLICY RECOMMENDATION – BURDEN SHARING

There is a need for a critical forum and discussion on how the private sector can contribute to addressing South Africa's critical health care resource shortages. A mixture of private/public services should be considered to free up public services for the most critical services and to prioritise the needs of the most underserved. A mixture of tax credits and various incentives to the private providers (both the four major ones and the numerous small private health care enterprises) should be considered for the purpose of increasing access and needed services in underserved regions and service areas.

5.2.4 PROGRAMME RECOMMENDATION – IMPROVING MANAGEMENT SYSTEMS

Health care HR shortages demand sophisticated management, information, and administrative systems that are fully equipped to engage all available resources (of both the private and public sector) and partners. Management systems could be strengthened through international exchanges of personnel, information, and training and through a formalised system of registration of private and public initiatives.

5.2.5 PROGRAMME RECOMMENDATION – RURAL SCHOLARSHIPS

More scholarships are critical for attracting suitable candidates from rural and other underserved areas who are willing to return to serve in those areas following graduation. Such scholarships should be coupled with relocation assistance and support. The provision of scholarship assistance to meet a critical need is also a good way to engage investment from the South African Diaspora in the Netherlands and the US.

5.2.6 PROGRAMME RECOMMENDATION – OTHER KEY SOCIAL SERVICE PERSONNEL

The South African Government should continue to attract social service, public health, and community health workers to fill gaps in homecare and other services that do not require health care qualifications and training. Community-based training programmes could be expanded. Public health graduates may also address shortages in administration in rural areas. Such initiatives lessen unemployment and underemployment in South Africa, creating more productive and learning community-service experiences.

5.2.7 PROGRAMME RECOMMENDATION – RURAL CENTRES OF EXCELLENCE

Rural centres of excellence are a means to create more productive community-service experiences, to encourage rural rotations, and to avoid burn out through regular rotations and promotions for going to HR-scarce areas. By using international exchanges to strengthen such centres, there is the possibility for increased

collaborative research and training, which will also attract both international and domestic health workers to serve for longer periods in these service areas.

5.2.8 PROGRAMME RECOMMENDATION – STUDENT LOANS AND REPAYMENT SCHEMES

Given current HR trends and patterns, the South African Government is subsidising the medical and other health care training for many doctors and other health care workers who end up leaving and/or working in the private sector. A mixture of medical education loans and financing schemes should be considered, which would allow doctors and other health care workers (as well as their private employers) to pay directly for the costs of education and training. Interest-free loans and/or grants could then be disbursed for those personnel willing to work in public centres in underserved areas.

5.3 Attracting South African Diaspora Health Care Worker Returns

5.3.1 FINDING – ATTRACTING THE SOUTH AFRICAN HEALTH CARE DIASPORA HOME

The possibilities for attracting the South African health care Diaspora home appear to be better in the UK than in the US and the Netherlands and for nurses rather than doctors and dentists. The study did not yield specific information about attracting other categories of health care workers back. However, those who are attracted to the private sector and salaries may be more difficult to attract back than others who have been working in the public sector and/or have been narrowly specialised for an extended period.

Encouraging Diaspora engagement through various forms of investments, training assistance, and temporary and circular returns is also a way to attract more Diaspora input and support and, in a few cases, may lead to long-term, more permanent returns. There are no obstacles in the three northern countries for the Diaspora returning, although all three countries are providing various incentives to retain skilled doctors and nurses (primarily salary and benefits). For the Diaspora, major constraints to returning are: South Africa's security situation; concerns about being able to practise again at an appropriate level and, in some cases, in the public health sector; and perceived bureaucratic hurdles in re-licensing and/or in regularising citizenship and meeting residency requirements again.

5.3.2 POLICY RECOMMENDATION – ADDRESSING CRIME AND SECURITY

In terms of policy and security measures, health care facilities and the protection of health care workers should be priorities in meeting health care needs. Police protection and security measures should be prioritised in health care facilities and for providers, particularly those working in underserved areas.

In general, prioritising crime and security issues is also an HR issue and progress in this area may well be the most effective intervention for encouraging the return of all skilled personnel.

5.3.3 PROGRAMME RECOMMENDATION – PROMOTING COLLABORATIVE INTERNATIONAL PARTNERSHIPS AND EXCHANGES WITH DIASPORA PARTICIPATION

Promoting official international collaborative partnerships and exchanges is a means to encourage more Diaspora returns. The presence of Diaspora health workers on such teams has also been shown to increase the likely effectiveness of the exchanges and allows the Diaspora members to check out and stage various return options. Such exchanges are also a way to encourage Diaspora investments, training, and temporary and periodic returns and, in a few cases, more long-term and/or permanent returns. For the Diaspora, the exchanges provide a neutral space to assess objectively their concerns about returning and to prepare to return.

5.3.4 PROGRAMME RECOMMENDATION – WEBSITE POSTINGS

HR shortages could be addressed through postings on key websites accessed by the Diaspora and other international health care personnel and through public and private channels. Openings on the website should be posted and updated on a regular basis. Several Diaspora organisations, particularly the professional organisations, medical alumni associations, and chambers of commerce, could be utilised to announce priority needs and specific openings. The Homecoming Partnerships, RHI and Placement projects all provide sites, information, and services to recruit and place health care workers.

5.3.5 PROGRAMME RECOMMENDATIONS – FACILITATING RE-EMPLOYMENT IN THE PUBLIC SECTOR

Facilitating the re-entry of doctors, nurses, and other health care workers willing to return to work in the public sector and particularly underserved areas should be a priority. These health care workers have the needed skills and services, are familiar with the South African health care system, and are most likely to make a long-term commitment to the country. However, their re-entry into the public sector should be facilitated through support with re-registration and return support and assistance. South African nurses in the UK should be particularly prioritised for such return assistance.

5.4 Attracting Other Foreign Health Care Workers to South Africa

5.4.1 FINDING – ASSURING EFFECTIVE INTERNATIONAL EXCHANGES

All countries resist losing health care workers but the benefits of international exchanges may accrue to all involved.

Nevertheless, the exchanges have to be well organised and within an institutional framework that provides the necessary support, cultural awareness training, and supervision. UK, USA, and Netherlands health care workers, particularly in the specialities of tropical and infectious diseases and public health, have an established tradition of working abroad. Likewise, many South African doctors and nurses are interested in improving their skills and expertise through educational programmes and opportunities offered abroad (but their employers are particularly concerned about losing them permanently).

Both the UK and the US have published major government reports arguing for an international global health service and exchanges. Netherlands doctors and nurses have a long tradition of service for two to three years abroad. In general, such programmes are most cost effective with exchanges for two to three years but even short exchanges and internships of six months may be effective if they take place within a formalised programme with ongoing activities. Currently, many international activities do not go through official channels, which explains the plethora of exchanges in the Eastern Cape. Also, government funding for these partnerships and exchanges in some cases has not immediately materialised whereas several exchanges are currently funded through private foundations and companies.

5.4.2 POLICY RECOMMENDATION – ORGANISING EXCHANGES THROUGH OFFICIAL CHANNELS

By promoting exchanges through official channels, there is likely to be more government ownership and support on both sides. Both parties will have an interest in ensuring that people return home and apply their skills effectively after the exchange. Most importantly, each department or ministry of health is better positioned to identify needed skills, training, and resources, as well to prioritise openings.

5.4.3 PROGRAMME RECOMMENDATION – WEBSITE AND DATABASE AND STRATEGIC PLACEMENTS

All international and overseas workers should be encouraged to register their services on return to South Africa. A website of information about openings, twinning relationships, and exchanges should be further developed and updated regularly. The South African High Commission and the embassies are in a good position to facilitate the collection of such information

and could be assisted by national professional and Diaspora organisations. A clearing house of information could be created to collect and document best practices and relevant reports.

5.4.4 PROGRAMME RECOMMENDATION – COLLABORATIVE EXCHANGES

More long-term collaborative exchanges and twinning relationships between institutions should be developed. Such exchanges could be used to develop rural centres of excellence and to facilitate research, training, and information sharing. Collaborative exchanges also allow both institutions to be invested in the outcome and to develop training and internship models that are appropriate to each situation.

5.4.5 PROGRAMME RECOMMENDATION – DEVELOPING PRIVATE/PUBLIC MODELS OF FINANCING

Financing for such international exchanges – namely twinning relationships/partnerships to support rural centres of excellence – should be sought through both private and public funding sources in order to sustain the work ahead.

SA Partners is a non-profit organisation based in Boston, Massachusetts that grew out of the activities of the former anti-apartheid movement in the US. Since 1997, SA Partners has supported joint activities between Mass Med and the Eastern Cape Province under a twinning agreement that addresses health and other sectors. Beginning in 2000, health-related efforts have been overseen by the Massachusetts-South African Health Task Force and facilitated by SA Partners (South African Partners 2007: 1).

The Masihlanganeni Network provides technical assistance, training, and support for Eastern Cape PLWHs and their NGO, health care, and government partners. Expected outcomes during the first three project years are: (1) establishment of a pilot wellness centre in the Port Elizabeth area; (2) increased utilisation of PLWHs in peer counselling, and in wellness, treatment readiness, and adherence support; (3) increased representation of PLWHs on planning councils and programme development and monitoring teams; (4) effective establishment of seven health-district-based PLWH mobilisation and support teams; and (5) increased NGO and governmental capacity to support and promote PLWH mobilisation and participation (Ibid: 2).

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- World Health Organization (2006b) Taking Stock: Health Worker Shortages and the Response to AIDS. Geneva: WHO.

APPENDIX B: INTERVIEWS/RESOURCES BY COUNTRY

NETHERLANDS

NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
NETHERLANDS			
Clara Blaauw	Consillium Education Tropical Medicine (COTG)	concil@xs4all.nl	Telephone interview with Welcker 13/02/07
Dr. Martin Boeree	Director of Lung Center, University of Nijmegen Nijmegen, Netherlands Also, Chair, Dutch Society for Tropical Medicine	PH: +31(0)24-68-59-911 M.Boeree@ulc.umcn.nl	Phone communication 15/02/07
Margaret Chotkowski	ECORYS Nederland BV	Postbus 4175 3006 AD Rotterdam Watermanweg 44 3067 GG Rotterdam PH: 010 453 8653 FAX: 010 453 07 68 Margaret.Chotkowsi@ecorys.com	Phone and email 15/02/07
Huib Cornielle	(physiotherapist working in South Africa) Hogeschool Leiden Polytechnical School in Leiden	Hogeschool Leiden Zernikedreef 2333 CK Leiden	Nurses education and one of the few training institutes for nurses providing tropical medical training, recommended Annet Scherpenisse
Barend Gerretsen	Royal Tropical Institute	PH: +31(0)20-568-82-39 B.Gerretsen@kit.nl	Sent email message since on mission, office recommended Professor Zwanikken
Geert S. Geut	Department, Head Southern Africa Division Sub-Sahara Department Netherlands Ministry of Foreign Affairs	Bezuidenhoutseweg 67 P.O. Box 20061 2500 EB The Hague The Netherlands PH: +31 (0)70 3485743 FAX: +31(0)70 3486607 geert.geut@minbuza.nl	Interview 12/02/07
Herman Matthews	Pediatrician from South Africa	PH: +31 (0)180628664 PH: 065165-9160	Interview 15/02/07
Dr. Minaar	Dentist from South Africa	Information not supplied	Interview 13/1/07
Dr. Mol	Lung surgeon originally from South Africa Stellenbosch Foundation Máxima Medisch Centrum	c/o Secretariaat Longziekten PO Box 7777, 5500 MB Veldhoven The Netherlands Tel: +31(0)402588251 info@holaandstellenbosch.nl PH: 31-40-8888250	Phone interviews 13/02/07
Dr. Fred Nederlof	Worldwide Surgery	p/a Rivium Westlaan 7 2909 LD Capelle aan den IJssel PH (organisation) : 06-53853605 FAX: 010-2020811 www.worldwidesurgery.org info@worldwidesurgery.org PH: +31(0)06-53853605	Phone interview 13/02/07
Harold Robles	Medical Knowledge Institute	PH: +31(0)181-486804	Initial phone interview Welcker

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NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
NETHERLANDS			
Nkhulu Sebothoma	Counsellor Bilateral, South African Embassy	30,Wassenaarseweg 2596 CJ The Hague PH: +31 70-392 45 01 FAX: +31 70-346 06 69 nsebothoma@zuidafrika.nl	Interview 14/2/07
Annet Scherpenisse	Professor, Hogeschool Leiden	Hogeschool Leiden Zernikedreef 2333 CK Leiden PH: +31-71-5188563	Interview 16/02/07
Ella du Toit	Coordinator, SANEC	2595 CL The Hague The Netherlands PH: +31 (0)70 347 0781 FAX: +31 (0)70 335 2766 info@sanec.nl www.sanec.nl ella.du.toit@sanec.nl	Phone discussion 14/02/07
Charles de Vries	Ministry of Health	PH: 070-340-5849	Phone discussion 15/02/07
Prisca Zwanikken	Head of Education Royal Tropical Institute	PH: 020 568 8459 P.Zwanikken@kit.nl	Phone and email communication 15/02/07 and several follow-ups

Other Future Contacts for Project Implementation:

DUTCH DOCTORS WORKING IN SOUTH AFRICA

(Provided by Clara Blaauw)

Carla van Turenhout: cvanturenhout@hotmail.com

Bart Hugem: happybart@hotmail.com

Milja van der Scheer: miljascheer@telkomsa.net

Sabina Verkuyl: sabine@hst.org.za

Simone van der Sar: svandersar@planet.nl

Jolmer Smit: jolmersmit@hotmail.com

Christel Kroner: ckroner@hotmail.com

Martijn Phaff: m.phaff@lycos.com

Marjolein Dieleman: M.Dieleman@kit.nl

- Recommended by Dr. Prisca Zwanikken

Dr. Sanjoy S.Nayak: S.Nayak@kit.nl

- Recommended by Dr. Prisca Zwanikken

PSO

Scheveningseweg 68 2517 KX Den Haag,

PH: 070-3388433

FAX 070-3502705

info@pso.nl; www.pso.nl

- Recommended by several NGOs and health care personnel for addressing international contract and benefit issues.

CordAID Lutherse Burgwal

10, 2512 CB Den Haag

PH: 070 3136 300

FAX: 070 3136 301

Cordaid: cordaid@cordaid.nl

- Recommended by Ministry of Technical Cooperation as organisation that delivers health assistance for that Ministry in South Africa and in other countries and is involved in health worker placements

UNITED KINGDOM (UK)

NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
UK			
Mr. David Amos	Director of Workforce UCL Hospitals	Trust Headquarters Ground Floor, John Astor House Foley Street London W1W 6DN PH: +44(0)20-7380-9840 MOB: +44(0)7884-473-357 FAX: +44(0)20-7380-9357 david.amos@uclh.org	Meeting scheduled for 3/20/07
Mr. Benedict David	Health Adviser Pan Africa Strategy Division, DfID	1 Palace Street London SW1E 5HE PH: +44 (0) 20 70231664 MOB: +44 (0) 7920546030 FAX: +44 (0) 20 70230342	Meeting 12/01/07 in London
Mr. Martin Fischer	King's Fund	11-13 Cavendish Square, London W1G 0AN King's Fund. m.fischer@kingsfund.org.uk	Meeting in Dec 06 in London
Mr. Cecil G Helman, MD	Senior Lecturer Department of Primary Care and Population Sciences Royal Free and University College Medical School	Holborn Union Building Highgate Hill London N19 5LW PH: +44(0)2072883249 FAX: +44(0)2072818004 c.helman@pcps.ucl.ac.uk	Meeting in London 15/1/06
Ms. Michelle Jimenez	Pathogens, Immunology and Population Studies The Wellcome Trust	215 Euston Road London NW1 2BE PH: +44 (0)20 7611 8641 FAX: +44 (0)20 7611 8352 m.jimenez@wellcome.ac.uk	Recommended by Sue Parks
Ms. Liz Kidd	Manager, International Migration and Workforce Department of Health	Liz.Kidd@dh.gsi.gov.uk	Telephone interview
Ms. Janet Kotze	First Secretary Republic of South Africa High Commission	Trafalgar Square, London	Meeting 14/12/06

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NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
UK			
Professor Anna Maslin	International Officer Health Professions Leadership Team Department of Health	Area G21 Wellington House 133-155 Waterloo Road London SE1 8UG PH:+ 44 (0)20 7972 4469 FAX: + 44 (020) 7972 4088 anna.maslin@dh.gsi.gov.uk	Telephone interview
Mr. A. David Napier	Department of Anthropology, University College London	14 Taviton Street London WC1H 0BW United Kingdom PH: 020 7679 2446 FAX: 020 7679 8632 d.napier@ucl.ac.uk	Electronic communication
Mr. Michael Parker	Chairman, King's College Hospital	Denmark Hill, London SE5 9RS PH: +44-(0)20-7346-3159 FAX: +44(0)20-7346-3436 Michael.Parker@kingsch.nhs.uk	Phone interview 09/02/07
Mr. Martin Schroeder	Rural Health Initiatives	54 Edgeway Road Oxford, OX30HE Martin.schroeder@rhi.org.za PH: +44 (0) 7905 887455 FAX: +44 (0) 1865 423324 www.rhi.org.za	Meeting 20/11/06 in London and 10/02/07 Oxford
Mr. Tiaan Visser	Netcare	18 Hannover Square, London PH: +44(0)2030088588	Meeting 7/2/07 in London
Ms. Zodwa Dube, RN	Association of SA Nurses in the UK	PH: +44(0)7719-077 718 MOB: 07795070364	Telephone interview Dec 06

Other Future Contacts for Project Implementation in the UK:

NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
UK			
Ms. Beverly Malone, RN, Phd, FAAN	Royal College of Nursing of the United Kingdom	20 Cavendish Square London W1G 0RN PH: +44(0) 20 7409 3333 www.rcn.org.uk	Several attempts to schedule an interview unsuccessful
Ms. Mmapula Tladi Small, RN	Director, Association of South African Nurses in the UK	Suite 368 456-458 Strand London WC2R 0DZ PH: 44(0)7951437820	For information campaigns and possible events with the High Commission

UNITED STATES (US)

NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
USA			
Ms. Kim Bardy	USAID Health Office	kbardy@usaid.gov	E-mail and telephone communication to set up interviews with USAID
Dr. Michele Barry MD FACP	Professor of Medicine and Global Health, Yale University	michele.barry@yale.edu PH: 1-203 688-2476	Telephone interview – 31/1/07
Ms. Jeanne Batalova	Migration Policy Institute	PH: 1-202 266-1908	Telephone contact – 29/1/07 and 31/1/07
Dr. Lincoln Chen	Global Equity Initiative Harvard School of Public Health (also, President of the China Medical Board, NYC)	Cambridge, MA Lincoln_chen@harvard.edu Erin_Judge@harvard.edu Nicole (Chen's assistant): 1-212-682-8000	Telephone discussion with Judge followed by e-mails with Chen
Mr. Michael Clemens, Ph.D.	Center for Global Development	1776 Massachusetts Ave. NW, Suite 301 Washington, D.C. 20036-1915 USA PH: +1 202 416 0722 FAX: +1 202 416 0750 mclemens@cgdev.org	Interview 30/1/07
Ms. Jennifer Cooke, Ph.D.	Center for Strategic and International Studies	1800 K Street, N.W. Washington, D.C. 20006 jjcooke@csis.org PH: 1-202-775-3135	Electronic communication 23 and 25/01/07
Mr. John Crowley	US Agency for International Development		Unable to meet
Minister Nobayeni Dladla	Embassy of the Republic of South Africa	PH: 1-202 745-6652 health@saembassy.org	Telephone discussions 24 and 26/01/07 and meeting 29/01/07
Dr. Robert Emrey	Director, Health Systems Division US Agency for International Development	14th Street, Washington, D.C. PH: 1-202-712-4583	Interview 30/1/07
Ms. Berta Fernandez	IOM	1752 N Street, N.W. Suite 700 Washington, D.C. 20036 BFernandez@iom.int	Interview 31/1/07
Ms. Amanda Folsom	Senior Associate Academy Health	PH: 1-202-292-6752	Telephone interview 29/01/07
Ms. Elzbieta M. Gozdzik, Ph.D.	Research Director Editor, International Migration Georgetown University	Harris Building 3300 Whitehaven St NW Suite 3100 Washington, D.C. 20007 PH: 202-687-2193 FAX: 202-687-2541 e-mail: emg27@georgetown.edu	Meeting 26/01/07
Ms. Victoria Guisinger	Associate Director of Programmes Lillian Carter Center for International Nursing Emory University	1520 Clifton Road, Room 438 Atlanta, GA 30322-4207 vguisin@emory.edu PH: 404-727-5229 FAX: 404-727-9676	Several email contacts

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NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
USA			
Ms. Elizabeth Higgs, M.D.	AITRP, Fogherty Center NIAIDS/NIH	EHiggs@niaid.nih.gov PH: 1-703-802-8211	Initial contact with Dr. Alex Fairfield 31/01/07, follow up for contacts at NIH and CDC
Mr. Gerald F. Hyman, Ph.D.	Senior Advisor and President, Hills Programme on Governance Center for Strategic and International Studies	1800 K Street, N.W. Washington, D.C. 20006 ghyman@csis.org PH: 1-202-457-8728 FAX: 1-775-3199	Meeting 22/01/07
Dr. Fitzhugh Mullan, M.D.	Contributing Editor, Health Affairs Clinical Professor of Pediatrics and Public Health	Suite 800, 2021 K Street George Washington University Washington, D.C.	Interview 29/01/07
Ms. Maura J. Nicholson	Bureau of Population, Refugees, and Migration Office of Multilateral Coordination and External Relations US Department of State	2401 E Street, NW, Suite L505 Washington, D.C. 20522-0105 PH: 1-202-663-3344 nicholsonmj@state.gov	Interview 30/1/07
	Also, from State/PRM Mr. Bryan Schaaf, Policy Analyst: schaafbj@state.gov Ms. Sonia Helmy-Dentzel, Migration Policy Officer: Dentzelsh@state.gov Ms. Mary Lang, Programme Officer, Africa Region: MLang@state.gov (interview on 30/1/07)		
Mr. Mead Over, Ph.D.	Senior Fellow Center for Global Development	1776 Massachusetts Avenue, NW Washington, D.C. 20036 PH: +1-202-416-0745 MOver@CGDEV.ORG	Interview on 30/01/07
Ms. Cheryl A. Peterson, MSN, RN	Senior Policy Fellow Department of Nursing Practice & Policy American Nurses Association	8515 Georgia Avenue, Suite 400 Silver Spring, MD 20910 PH: 1-301-628-5089 FAX: - 301-628-5349 cheryl.peterson@ana.org www.nursingworld.org	Telephone interview on 24/01/07
Ms. Marla Salman, ScD., RN	Professor and Dean Nell Hodgson Woodruff School of Nursing Professor of Rollins School of Public Health Emory University	Rollins School of Public Health Emory University Atlanta, Georgia	Email contact through Anita Alero Davies and Victoria Guisinger: vguisin@emory.edu
Dr. Robert Schooley, M.D.	Professor and Head of Infectious Diseases University of California, San Diego	University of California, San Diego Medical School San Diego, California	Initial phone contact with assistant 26/01/07
Mr. Paul Seaton, Ph.D.	International Programmes Johns Hopkins School of Public Health Department of International Health	Baltimore, Maryland	Telephone interview 26/01/07
Mr. James Sykes	Assistant to the Executive Director, The AIDS Institute, National Office	1705 DeSales Street, NW, Suite 700, Washington, D.C. 20036	Telephone interview 25/01/07 and assistance with publication
Ms. Emily MacGillivray & Dr. Al Teich	AAAS, International Programmes	emacgill@aaas.org PH: 1-202-326-6600	Telephone conversation with MacGillivray 25/01/07

NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
USA			
Ms. Natasha Sakolsky	Field Programmes Director Family Health International	Arlington, Virginia PH: 1-703-516-9779	Telephone conversation 25/01/07
Mary Tiseo	Executive Director South African Partners	mtiseo@sapartners.org PH: (617) 443-1072	Telephone interview 23/01/07

Other Future Contacts for Project Implementation in the USA:

NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
USA			
Ms. Tracey Hudson	RHI recruitment	PH: +27 31 764 4740 FAX: +27 31 7643753 computer FAX: +27 88 031 7644740 MOB: +27 83 2126481	Meeting 20/11/06 in London
Dr. Samuel Adeniyi Jones	Department of Health and Human Services	Washington, D.C. PH: 1-301-443-9943	Left messages on 23/01 and 26/01 – contact suggested by Minister Dladla
François Baird	Stellenbosch Foundation C/O Baird's communications Management Consultants	1850 M Street NW Suite 550 Washington, D.C., 20035 PH: 1-202 777 3525 FAX: 1-202 289 4141 Francois.Baird@bairdscom.com	Possible contact for future Tokten type initiatives with Diaspora community
	Baylor University Programme	Baylor College of Medicine One Baylor Plaza, Houston, Texas 77030 PH: 1- 713-798-4951	Private centre establishing centres abroad funded by pharmaceutical companies, recommended by Dr. Mullan
Dr. Gilbert Burnham	Johns Hopkins University School of Public Health	GBurnham@jhsph.edu PH: 1-410-955-3928 or 955-7934	Telephone conversation with Dr. Seaton 26/01/07
Peter Wench	Johns Hopkins University School of Public Health	PWench@jhsph.edu PH: 1-410-955-9854	
Crisis Corps	Crisis Corps / US Peace Corps	http://www.peacecorps.gov/index.cfm?shell=resources.former.crisiscorps.openpos	Recommended by Louise Krumm, former PC Director
Ms. Patricia Cuff, MS, MPH	Study Director Board on Global Health Institute of Medicine	Keck Building 500 Fifth Street, NW Washington, D.C. 20001 PH: +1-(202) 334-3969 FAX: +1-(202) 334-3861 Pcuff@nas.edu www.iom.edu	Recommended by Professor Mullan
Dr. Charles DeBose	Director Office of Health and HIV/AIDS AFRICARE	PH: 1-202-328-5386 FAX: 1-202-387-1034	Unable to establish contact, messages left on phone

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NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
USA			
Dr. Robert A. Hahn	Epidemiologist, Centers for Disease Control (CDC)	Community Guide Branch National Center for Health Marketing (NCHM) Centers for Disease Control and Prevention 1600 Clifton Road NE Mailstop K-95 Atlanta, GA 30333 communityguide@cdc.gov	Recommended by Dr. Helman, UCL (possible follow-up)
Robert Hecht	Gates Foundation and World Bank	Bill and Melinda Gates Foundation PO Box 23350 Seattle, WA 98102 PH: (206) 709-3100 info@gatesfoundation.org	Contact by email to be followed up, recommended by Dr. Hatzios, World Bank
	International Health Volunteers	http://www.internationalhealthvolunteers.org/	Recommended by Lloyd Feinberg, USAID for possible follow-up
Dr. Henry Mosely and Ms. Amy Tsui	Gates Leadership Institute	Johns Hopkins School of Public Health PH: 1-443-287-3833	Recommended by Dr. Paul Seaton for possible follow-up
Ms. Barbara Nichols	Chief Executive Officer Commission on Graduates of Foreign Nursing Schools	3600 Market Street, Suite 400 Philadelphia, PA 19104-2651 PH: 1-215-222 8454 FAX: 1-215-662 0425 bnichols@cgfns.org www.cgfns.org	Recommended by Cheryl Peterson for credentialing and certification issues
Ms. Sonja Pilusa Mr. Ya Diul Mukadi Ms. Manisha Bharti	Family Health International	spilusa@fhi.org.za YDMukadi@fhi.org.za MBharti@fhi.org	Suggested by Sakolsky for follow-up for Linkages with PEPFAR
Ms. Ellen Schweitzer and Mr. Toby Stillman	Health Programmes Save the Children	Washington, D.C. PH: 1-202-261-4691 and Stillman at PH: 1-202-413-8530	Messages left for future follow-up
Alan Winter	Director of Research Division World Bank	The World Bank 1818 H Street, NW Washington, D.C. 20433 USA PH: 1- 202- 473-1000 (main number)	Recommended by Mead Over for follow-up

SWITZERLAND

Other Future Contacts for Project Implementation:

NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
SWITZERLAND			
Dr. Mireille Kingma	Nurse Consultant International Council of Nurses	3, Place Jean-Marteau 1201 Geneva Switzerland PH: +41 22 908 0100 FAX: +41 22 908 0111 kingma@icn.ch www.icn.ch	Recommended by Cheryl Peterson, ANA

REPUBLIC OF SOUTH AFRICA

NAME	TITLE / ORGANISATION	CONTACT DETAILS	NOTE
SOUTH AFRICA			
Meagan Wood	Director, Homecoming Revolution	www.homecomingrevolution.co.za	Electronic communication only
Suzanne Johnson	Monitoring & Evaluation The Placement Project	Block D, Momentum Building 1109 Duncan Street Brooklyn, Pretoria South Africa 0181 PO Box 74789 Lynnwood Ridge 0040 South Africa PH: 012 460 5521 FAX: 012 460 5769	Several emails during November 2006
Dr. Percy Mahlathi	Department of Health Pretoria, South Africa	percyma@telkomsa.net	E-mail contact
Mr. Ephraim Phahlane Mafalo	President, Nursing Organisation of South Africa (DENOSA)	605 Church Street Box 1280, Pretoria 0001 South Africa PH: +27 12 343 2315 FAX: +27 12 344 0750 info@denosa.org.za http://www.denosa.org.za/	E-mail contacts unsuccessful – to be tried further
Ms. Thembeke T. Gwagwa	General Secretary, Nursing Organisation of South Africa (DENOSA)		
Mr. Shaun-Allan Smith	The Foreign Workforce Management Programme South African Department of Health	PH: +27-12-312-0722 FAX: +27-12-312-0555 smiths@health.gov.za	E-mails sent but no reply to date, recommended by Janet Kotze
Dr. Gustaaf Wolvaardt	Foundation for Professional Development	P.O. Box 74789 Lynnwood Ridge 0040 PH: +27-12-481-2031 MOB: 083-300-8271 FAX: +27-12-481-2083/2108 gustaafw@foundation.co.za www.foundation.co.za	To be contacted

RUDASA COMMITTEE MEMBERS 2006

RUDASA is a professional organisation of doctors working in rural areas throughout South Africa and provides a good resource of contacts for future programme implementation. The table below is taken from RUDASA's official website detailing the current contact information for its committee members.

NAME	PORTFOLIO	CELL. NO.	OTHER NO.	EMAIL
Bernhard Gaede	Chairperson		036 4881570(w) 036 4881156 (fax)	besam@lantic.net
Will Mapham	Vice-Chairperson	0823255842		william.mapham@gmail.com
Keshena Naidoo	Secretary + Treasurer	0842595503	031 4626844	keshena@iafrica.com
Elma de Vries	Student Portfolio Former Chairperson	0828286259	021 3725159	elmadv@cybersmart.co.za
Helmuth Reuter	Ex-officio (Univ.)		021 9389108 021 8865290	HR@sun.ac.za
Jenny Nash	KZN rep	0825327537	035 5741004	
Hannes Steinberg/ Jackie Mahlatsi	Free State reps	0829724622		Gnogwjs.MD@mail.uovs.ac.za mahlatsm@fshealth.gov.za
Selby Maphophe	Limpopo rep	0820421032		
Alwyn Rapatsa/ Ben Guant	Eastern Cape reps	0722645492 072-2630333	0475759576	phutirapatsa@webmail.co.za gaunts@gmail.com
L. Nkombua	Mpumalanga rep			lushiku@lantic.net
Ian Couper	North West rep / Past Chairperson	0828010188	012 2531796 0117172602	couper@lantic.net
Louis Jenkins/ Earle du Plooy	Western Cape reps	0837951065	044-8024528	ljenkins@pgwc.gov.za eaduplooy@pgwc.gov.za
Vacant	Northern Cape			
Jonathan Pons	Swaziland rep		09268 3434124 09268 3434133	mabuda@realnet.co.sz
Vacant	Lesotho			
Ntoden Ndumato	Past Chairperson	0828782855	0828584219 015 9621307	mdumato@samedical.co.za
Steve Reid	Past Chairperson	0834471907	031 2601569(w)	steve@hebron.za.net
Edward Bowen-Jones	Past Chairperson	083 2507190	031 2664557	ebjones@mweb.co.za
Jannie Hugo	RHI (ex-officio)	0823722435	012 3541430	Jh38@mweb.co.za
Neethia Naidoo	WONCA Rural Working Group	0823361687	033 5011110(w)	docnn@iafrica.com

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